Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CRAWFORD (5:30 M **Physician** 2008 /Medical 4a. Facility Name (If not restrution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 7, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☐M 2 ☐ F Months Days Hours Virginia 83 Director 223 24 4088 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County "natural", or Items 23a or 28a-f show older Examiner must be notified at 1 ☐ Yes 2 No Director MD Oueen Anne's Queenstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Woods Road 21658 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XFes 2 □ No If Yes, Give Year or Dates:1942-45 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) Elementary/Secondary (0-12) Scandia Manufacturing Tool & Die Maker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill int of Health and Mental H Be Ashby Crawford Nancy Cordell Shifflett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora K. Crawford/Wife 108 Woods Rd Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or otl Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-9-2008 Ardent Crematory Hanover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications to taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) physician at s the burial-t Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I FORTH AVEUR 78W | MIFFLITENS 76W | DIANGE 7ES 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 Tyes 3 Probably 4 Unknown Completed has been TELLITA! 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D 6/86 V 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier St. Baltmani, MD 21201 641 cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Ma	arylanc		artmen rtificat					giene Reg. No.	00	0.8	0.5	502
18	Physic	ian	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month		/	Year	3. Time of	
	/Medi	cal	William Cohee I				4 00	_			Month 2	13 ^{Day}		Year 08	13.	41 M
	Exami	ner	4a. Facility Name (If not institution, give 202 S. BALTIMORE	AVE.					Location of	of Death			County o			
29430	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. la	st birthday)	If Under	1 Year	CITY If Under		8. Date of Bir	th	JICE .	9. Birthpl	ace (State o	r Foreign
	Director		222-40-9635	©M 2□F 52		Yrs.	Months	Days	Hours	Min.	JULY 29	9, Year)	955	Coun. DEL	AWARE	5
-	pu »		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	oation							Ta.	21	h . I ! !
	faryla shoved at	ō	MD WORCES	gar		N CIT								"	od. Inside Cit 1 ∑]Yes	•
	h the Marylan r 28a-f show notified at	Director	10e. Street and Number	. LIX	OCEA	N CII	1 10f. Zip	Code				10a Citi	zen of W	hat Coun		
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	death w	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13.				igin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race			
9	ours after de ral", or item Examiner r		1X Never Married 2 Married	1 ☐ Yes 21 If Yes, Give	No		1 ☐ Yes		Specify:		Hican, etc.)		Specify:	, White, e		
21215-0036	"natural", "natural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:											WHITE	
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212	within liene.	Completed	Elementary/Secondary (0-12) UNKNOWN	College (1-4or 5	i+)		ENDER	,,,,,,,,	7			RE	STAU	RANT		
P	be filec ttal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Surname)		
ylar	Menta	2	WILLIAM HARRINGTO	ON COHEE,	III				HA	NNAH	MARVEL	J				
Maryland	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship (7	ype. Print)							I Route Numb			State, Zip	Code)	
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Baltimore,	Pages lent of l nt: If ite		1 🗶 Burial 2 ☐ Cremation 3 🗶		cei	metery, crei	matory or o	ther plac					cation - C	•		
ij	artme ortant injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		BAR	RATTS	CHAP.				-		DERIC	-		
Ba	permit. P Departm Importar any inju		Hanse yn S	That						DLL	RY-SHOR E 19943	RT FU	INERA	L HO	ME	
			23a. Part1. Enter the disease, or comp	lications that caused	the death.										Approximate	3
45	Physician		shock, or heart failure. List only in Immediate Cause (Final disease or condition	0		Ü	3) 10	. 5			100			1	Interval Bety Onset and D	Death
	/Medical		resulting in death)	a. Due to (or as	The state of the s	YOCA. ence of):	FDIF	- 4	MERI	CITI	GN			H	W m//	VS
	Examiner		Sequentially list conditions.	b												
1	ed sit	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence off:										
V	cate be executed ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):										
8760,	e be e siciar buria	g		d	·											
89	The law requires that the death certificate be- ite has been signed by the attending physicial age 2 should be detached for use as the burn	Physician/Medical		0												
Box	leath certifica attending ph I for use as th	Jug N	23b. was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic pr	ognancy				2	23d. Date	of delive	ry	
O. E.	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (sp						Mon	th	Day Y	'ear
P.0	res that the death cer igned by the attendir be detached for use		9 ☐ Unknown Part II. Other significant conditions on	entributing to death by	it not recult	ing in the u	nderlying o	aueo give	on in Port I		23a Did to	obacco u	en contril	nuta ta th	e cause of de	onth?
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or Vital	Physician: r this certifica ral director, j	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2∐El	R/Outpatien	t 3□D0	Othe	31.		ne 5 X Resid		3 ∏Othe	r (Specify	·)	
0 _	£		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur	ry 2	28b. Time of Injury		8c. Injury Work			28d. Describe I				<u>/</u>	
Siol	Attending r death. ector: After by the funer	atic	2 Accident investigation	(, 50.7	,,	М		Yes 2 □ I	No						
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju- building, etc	ry - At hom c. (Specify)	e, farm, str	eet, factory	, office		2	8f. Location (5 City or Tox	Street an vn, State	d Numbe	r or Rurai	Route Numi	ber,
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	Hos 24 ho Fun etely	Medical	29a. Certifier 1 Certifying Phyone) Check only one) 1 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination	edge, deatr on and/or in	vestigation	at the tim , in my o _l	ne, date an pinion, dea	id place, a ath occurr	and due to the ed at the time,	cause(s) date and	and man I place, a	ner as stand and due to	ated. the cause(s))
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the I	Me	29b. Signature and title of certifier	maining 3to			290	. License	number			29d. Dat	e signed	(Month, L	Day, Year)	
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	1		30. Name and address of person who	1		23a) (Type,	Drint)									
	`		DOROTHY C. HOL	ZNORTH,	M.D.		20	23 5	WOW	5,	SNOW	HILL	140	210	763	
12	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ır's Signatu	re	46					7				

State Registrar

FEB 2 5 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Februar John Commodore, Jr. 2008 0 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 5 Chever If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 🛛 M 2 🗆 F Maryland Director 216-34-8424 April 18, 1930 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Landover MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or USA 20785 7746 Burnside Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Black 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Rosie Harrod John Commodore, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7746 Burnside Road, Landover, MD 20785 Rosalee Commodore - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brown's Cemetery 2/21/2008 Port Republic, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bladep a Sewell Funeral Home, PA, 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheros claro Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-tran Due to (or as a consequence of) Box 68760, physiclan Physician/Medical the as attending properties for use as 23c, if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. the detached 9□Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2 No 3 Probably 4 Jonknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe certificate 2 No Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2∏ No 1 Inpatient 2 ER/Outpatient 3□ DOA ပ this funeral 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deal To the Funeral Director n by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Arthur Calcagno, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) hysician/ Month Day February 13, 2008 1312 hrs Me Examiner Arthur Calcagno.Jr 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Glenela 13905 Burntwoods Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Months Davs Hours O Countr NewYork Director October3,195 1 X M 57 2 F 122-38-3365 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 X No 28a-f show Glenelg s 23a or 28a-f show e notified at once. i. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Maryland Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21737 U.S.A 13905 Burntwoods Road 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X No Yes 4 X Divorced If Yes, Give Yeer Specify: White Yes 2 X No specify: Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 21215-0036 Consultant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Maimone Arthur Calcagno, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 3244 72nd Street, Elmhurst.New York 11373 Andrea Calcagno 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 XX remation 3 Removal from State permit. Pages Department of Important: I Baltimore, Maryland 2-18-08 Bayview Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Marzullo Funeral Chapel, P. 5009Harford Road, Baltimore, Maryland 21214 michael margula Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ysician Between Onset and failure. List only one cause on each line. /ledical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical the attending physician of for use as the burial -AMENDED UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Day 3 Ectopic pregnancy Month Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ò Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, ficate has been si , page 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No certificate Yes 2 V No 1 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica director, Be examiner? Hospital: 1 Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 this ၉ 1 V Yes funeral 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending the To the Funeral Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I within 24 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 13, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registra

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

Assistant Medical Examiner egistrar's Signatur

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01126 State of Maryland / Department of Health and Mental Hygiene 2008 05505 Diane Clifford 1- For State
Registrar/Ameno#1_PerMF0R02-15_08cm Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 8, 2008 1000 hrs **Medical Examiner** Clifford Linda Diane c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Foreign WASH 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 04/13/1949 Country)D.C Director 58 579-66-0682 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Adelphi 28a-f show MD P.G. Director 10g, Citizen of What Country 10e. Street and Number 10f, Zip Code 20783 United States 9708 23rd Avenue 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other injury or other transmer. Yes If Yes, Give Yea Yes 2 X No specify. Specify: Black Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Department Of College (1-4 or 5+ Elementary/Secondary (0-12) Computer Analyst GED Army 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Lena Greene Maurice Sutton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9708 23rd Ave., Adelphi Maryland 20783 Walter Clifford, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 2/16/08 Adelphi, MD George Washington 4 Donation 5 Other Specify. 420 H St.NE. Wash.DC. 20002 Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. Henry Funeral Chapel Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Intra-abdominal hemorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Complications of hysterectomy Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi Physician/Medical X UNPENDED AMENDED A-b, 27, perME, C877, 3/5/08 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown Š Completed Records, 24a. Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy death? performed? ✓ Yes 2 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: Other; Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA Inpatient this 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification XNatural Yes 2 Division Director: Pending hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined 24 hours Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within 2 To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 9, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (15 on 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day Year) FEB 1 5 2008 32. Registrar's Signatur State

Registrar

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32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 08 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 112991 Cumberland lanor If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs 163-14-25 2 75 GREENSburgPA **Director** Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, the Medical Examinar must be notified at md Allegany Cum berland 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ChristieRd , N.E. -8326 1). S.A 10301 21502 Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0020 Specify: WhITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental CRAW Ford JOSEPH KENNEDY LOTTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place Costa Mesa Ca 92626 Date 20c. Location - City or Town, State GARCELL TAREN 884 LIARd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dapartmant of Pimportant: If ite 1 Burial 2 □ Cremation 3 □ Removal from State WAYNESBURG, Pa 4 ☐ Donation 5 ☐ Other (Specify) Greene Co. Memorial Park 2-7-08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 32 S. Second St. Oakland, MD 21550 Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for usa as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No δ cartificata has been si ractor, paga 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TLI Yes 2 HNO 1 ☐ Yes 2 ☑ No funeral diractor, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

ior Attending Physician: Tha law requires that tha daath certificate ba axecuted within 24 hours after death.

To the Funeral Director: A complataly filled in by the fu after death. Hospital To the

> State Registrar

edical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 - Homicide

29a. Certifier (Check only one)

2008 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08-01360	
Landon Eney	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

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Street and Number 220. I of Months 20ys 10b. City, Town or Location 10	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Perbruary 16 4b. Facility Name (In or institution, give street and number) Johns Hopkins H	1. Decoderit's Name (First, Midde, Last) Decoderity Name (First, Midde, Last) Decoder	Reg. No. Poscedaris Name (First, Midde, Last) Facility Name (Fir

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:00 PM Barbara L. Eaton February 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 2, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 25€ Director 022 20 1487 80 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐Yes 2X No Director Howard Elkridge MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 7236 Montgomery Rd Apt 2A 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1x Never Married 2 ☐ Married Maryland 21215-0036 Specify Black 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper State College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Armstead Eaton Iola McKnight ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole I. Bernard/Daughter 5533 Mystic Court Columbia, MD 21044 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 2-11-2008 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 Coll 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hyperhophic **Physician** disease or condition resulting in death) /Medical Examiner ota Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequace of) Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical use as ed by the attending I detached for use as IF FEMALE: lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performed: 2 No 1∐ Yes 2 🙀 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2ER/Outpatient 1 Inpatient 2 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director: After ty filled in by the funera Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

(J) or

Registrar

DHMH 17 Rev 1/2001

Sabapathi Kamesh 31. Date filed (Month, Day, Year) FEB 11 2008



7) 30641

February 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01281 State of Maryland / Department of Health and Mental Hygiene Crystal Lynn Everett Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 13, 2008 1238 hrs Medical Examiner Lynn Crystal 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min CountryMaryland Sept. 17,1963 Director 219-82-7356 1 M 2 X F 44 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 No or 28a-f show Washington Hagerstown or items 23a or 28a-f shomust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21740 U.S.A. 1024 B Spruce St. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funera 11. Marital Status White, etc. Armed Forces 1 Never Married 2 X Married Yes White Specify: Yes 2 X No specify: Divorced If Yes, Give Year Widowed other than "natural", the Medical Examiner <u>چ</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Homemaker 8 Domestic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carson Mills Delores Baker If item 27 is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 2 Timothy S. Everett/Husband 1024B Spruce St., Hagerstown. MD 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD Smithsburg Crematory 2/20/2008 | Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval 23a. Part I. Enter the disease, or conformations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** each line. failure. List only one cause on Death /Medical a Complications of bronchoscopy Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/2/08 amh X UNPENDED the attending physician led for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown signed ğ Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy death? performed certificate has page 2 s 1 🗸 Yes ✓ Yes 2 2 No 26.Place of Death (Check only one) 25. Was case referred to medical : Hospital or Attending Physician: Division of Vital Be Other [Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this 1 V Yes No After thi funeral d 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Excessive hemorrhage status post Certification: 1 Yes 2XX No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Pending transbronchial biopsy 2/5/08 Unk<u>nown</u> 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State Washington Co. Hospital 3 Could not be Suicide determined (Specify) Hospital agerstown Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

OCME 2006

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 15, 2008

FFR

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

29b. Signature and title of certified

Laron Locke MD.

31. Date filed (Month, Day, Year,

			For	State of Marylar			Mental Hyg	iene	The Profes (robus as an a
			1 - State Registrar 1. Decedent's Name (First, Middle, La	ct)	Certificate	e of Death	2. Date of Deat	og. No.	3. Time of Death
	Physici		JOCEP 1	+ FLBERT			Month 2 -	Day - Year	950 M
	/Medio		4a. Facility Name (If not institution, giv	e street and number)	4b. City, T	own, or Location of Death		4c. County of Death	
			ST. CATHELIN	ES NURSING	Jast birthday) If Under 1	Year If Under 24 Hrs.	BURGIN	B FREIDS	KICK
н	Funeral Director		5. Social Security Number 6. S 216-14-7936	Sex 7. Age (In yrs. IXM 2□F 83		Days Hours Min.	8. Date of Birth (Month, Day, April 26	Year) 9. Birthi Cou. 1924 Was	place (State or Foreign plry) shington DC
	D		Usual Residence of Decedent				ripilii 20		
	within 72 hours after deeth with the Maryland ane than "naturet," or itama 23e or 28e-f ahow he Medical Examiner must be notified at	5	10a. State 10b. County Maryland Freder		ty, Town or Location Frede:	rick			10d. Inside City Limits 1 X Yes 2 □ No
	28a-f	recto	10e. Street and Number		10f. Zip 0		10	0g. Citizen of What Cou	ntry?
	h with	Funeral Director	35 All Saints S	treet, Unit 5		21701		United S	tates
	ama 2	iner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Decede	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	rs afte		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No WO:	rId r II 1□ Yes 2	No Specify:		Specify: Wh	ite
21215-0036	2 hou	Completed by	15. Decedent's E	ducation	16a. Decedent's Usual	Occupation	tring	16b. Kind of Business/Ir	dustry
218	ithin 7	nple	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	,	Killig	Federal Go	rrownmon t
	filed with Hygiene. other the		17. Father's Name (First, Middle, Last		Civil Ser		ne (First, Middle, A		verment
lan	should be in and Mental is marked o	To Be	Joseph C. Elber				J. Easby		
Maryland	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23s or 28s-1 show other traumatic avent, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship	**	7	(Street and Number or Ru			
_	1 and 2 Health			Wife	35 East A. Place of Disposition (Nam.	ll Saints St		, Frederick	
Jore	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery crematory or other Saint John's	her place) Febr	uary ,	Frederick,	
Baltimore,	교문문을 .		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Cemetery 22. Name and	Address of Facility	2000		ial y land
ä	Depa Impo) CCC	MO1	Keeney 106 Eas	& Basford F st Church St	'.A. Fune reet. Fr	ral Home ederick. MI	21701
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.					Approximate Interval Setween Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	CELL CARO	CINOMA &	of Lui	NG	Criser and Death
	/Medical Examiner		1	Due to (or as a consec	quence of):				
		Jer	Sequentiatly list conditions, any leading to immode cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons.	uence of:				
V	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	cate be executed physicien and the burial-transit	al E	rossing in dounty basis	Due to (or as a consec	quence or):				
9	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai		_ d					
Вох	eath certific attending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		egnancy		23d. Date of deliv	,
.O.	the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o				Month	Day Year
Δ.	res that the de igned by the be detached		Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying ca	ause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	Completed by	Colowaly	ARTORY DI	SEASE		1 □ Ye	as 2 □ No 3 □ Pro	bably 4 Dunknown
000	e iaw requ hes been je 2 shoult	piet	ALZHEMER	S DISEASE			24a. Was a autops	n 24b. Were aut	opsy findings available ompletion of cause of
E E	The cete he	Com	PROTTATE	CANCER			perforr	ned? death?	2□ No
Vita	nding Physicien: The th.: th.: After this certificete funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ath (Check only on		
of	Phys ar this aral di	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of 28	A 4 Nursing F Bc. Injury at Work?		ow injury occurred	fy)
ion	uttanding death. ctor: Afte	atio	1 Naturat 5 ☐ Pending 2 ☐ Accident investigation	in	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of	br Atterde	Certification:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		nome, farm, street, factory,	, office	28f. Location (St City or Town	reet and Number or Run n, State)	al Route Number,
	To the Hospitei or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge death occurred a	at the time, date and place	and due to the c	auso(e) and manner as	hatet
	a Hos 24 hos a Fun letely	Medical	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or investigation,	in my opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
	vithir To th	Me	29b. Signature and title of certifier	1	29c.	License number	2	9d. Date signed (Month)	_
	,		* Spoken	A dante		0006428	38 1	EBRUARY	15,2008
	15		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	FIEIN DA	1722	.0	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Fjegistrar's Sign	ature &	TICLIJ TIT	1100		
	Regist		FED 0 E	2008 4 4000	Co Comment				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year FEBRUARY 2008 Patrick Leo Ferry 5 /Medical County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death LIVISTA MEDICAL CENTER LAPLATA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Days Hours Min. 1 M 2 □ F 86 198-05-7536 May 5, Pennsýlvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits XXYes 2□No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>3628 Old Washington Road</u> **USA** 20602 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White ģ 3X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemical Technician Dupont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dennis Ferry Rose Quinn Ferry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Marily Woodey/ Daughter</u> 3628 Old Washington Rd. Waldorf, Maryland, 20602
ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Feb. 7,2008 Waldorf, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Huntt Funeral Home CM01362 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as en eng Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other tany injury or other traumatic event, the

Physician

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be Certification: To

investigation 6 Could not be determined 3 Suicide 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Steven

1 Certifying Physician: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29d. Date signed (Month. Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 08 2008

Smith

32. Ragistrar's Signature

5 GARRETTAVE

LAPLATA, MD 20646 positi

After

after death

within 24 hours a To the Funerai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 📗 🗎 State Registrar Amend #5, perFH, C877, 3/4/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Richard 2 07 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Buckinghams Choice Health Care Center Adamstown Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | DEC . | 14,1918 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 9269 579-05-9869 6. Sex 1 2 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 89 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "neturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at Frederick Maryland Adamstown 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Be Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer N.A.S.A. 16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 90 Thomas Η. Fenton Agnes Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Item 27 Charles E. Fenton / Son 4010 cloverland Dr./ Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Important: If It eny injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Feb. 12,2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A,. Mone 1621 Opossumtown Pike/ Frederick, MD 23a. Part. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final Physician disease or condition resulting in death) 61 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed buriai-transit ettending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available pnor to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place a eath Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital or A 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Wen 31. Date filed (Month, Day, Year) State 12 2008 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygien		- 1
State of Maryland / Department of Fleath and Mental Hydrene	$ \cup$	-

			1 - For State Registrar	Otato or ma		Certificate of			g. No.	00010
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	1	3. Time of Death
	Physic /Medi		Russell Glenr	n Frien	đ			Feb. 1,	Day Year 2008	4 P M
	Exami		4a. Facility Name (II not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
			Garrett County Me	morial Hos	pital	0ak	land		Garre	tt
	Funeral Director		213-24-6142	ex 7. Age 7. Age 7. Age 7.	(In yrs. last birth 9 Yı	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 10	9. Bir Co , 1928 Ma	thplace (State or Foreign ountry) ryland
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Aaryl F sho	ō	MD Garr	ott		0akland	1			1 ☐ Yes 2 📉 No
	the l	Director	10e. Street and Number	ett		10f, Zip Code		10	g. Citizen of What C	ountry?
	with le or	٥	1089 Kings Run Ro			101, 21p 3333	21550			outiny :
	ns 20	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of I		ecify Yes or No-	USA 14. Race - Ame	erican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28a-1 show any njury or other traumatic svant, the Medical Evalution must be notified at ADES.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	wwii	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🏋 No		Rican, etc.)	Black, Whi	te, etc. hite
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a. D	Decedent's Usual Occur	oation during most of work	ina 1	6b. Kind of Business	/Industry
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Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic svant, Lie M.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	should I	2	Wesley McClel	land F	riend		Franci	s Ma	ude F	riend
lar	and and ls m		19a. Informant's Name/Relationship (**		Mailing Address (Street				
	Health Health tem 27 I		Mary A. Friend/ W	life		089 Kings R				
Baltimore,	of H of H if iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D	Disposition (Name of crematory or other pla	сө)	Date 2	loc. Location - City or	Town, State
Ē	Pag ment ant: I		` 4 ☐Donation 5 ☐ Other (Specif	(V)	Garrett	Co. Mem.	Gds. 2/5/0)8 (Dakland, M	aryland
ä	permit. Pages 'Department of Himportant: If ite any njury or of once.		21. Signature of Funeral Service Licen	ISB0		22. Name and Addre	ess of Facility	32 S	. Second	St.
<u>m</u>	8978		Bralling	and		Stewart Fu	meral Hom		AND DESCRIPTION OF THE PROPERTY OF THE PROPERT	21550
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line a	he death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 2 Mon This
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1	-513-		
		_	Sequentially list conditions,	b. aort	c sten	tals				years
-	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	corrandaerine Ol).				,
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of	1.				
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	ding p		IF FEMALE:	23c If was outcome of	nregnanov.					-
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of de Month	Day Year
s, P	res that igned I be det	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in t	he underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rg	quire n sig uld b	pe pe	Chronic alle	esic ast	hma	,		1 🗋 Ye	s 2 □N 0 3□P	robably 4 Unknown
00	w requi	lete	·	U				24a. Was ar	24b. Were a	utopsy findings available
Vital Record	The lav	Completed		-				autopsy	prior to death?	completion of cause of
tal		Ö	25. Was case referred to medical				Of Blace of Death		1 Yes	s 2 No
>	Physician: this certific ral director,	To B	examiner?	Hospital:	2 ER/Outp	atient 3 DOA Ot	26. Place of Death		nce 6 Other (Spe	- alf.)
o	Phy or this oral o		27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 28c. Inju		28d. Describe ho		ecny)
Division	th. : After s funer	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Y <i>ear)</i> Inj		rk?]Yes 2□No			
/isi	Attar dea ctor	fica	3 Suicide 6 Could not b	9	y - At home, farm	n, street, factory, office		28f. Location (Str	reet and Number or R	ural Route Number,
<u>S</u>	spital or Attanous after death ours after death teral Diractor: filled in by the	Certification:	4 Homicide determined	building, etc.	(Specify)	,, ,,		City or Town		
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best of niner: On the basis of e and manner state	examination and/	death occurred at the ti or investigation, in my	me, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier	1 /	/	29c. Licen			d. Date signed (Mon	th, Day, Year)
			V/M/MBUNI	ta by	in A.	N	76650		2-1-5	2008
		10	30. Name and address/ot person who	completed cause of dea	1h (Item 23a) (T	voe Print)			0-10	
		4 VA	murgaret a K	aiser ud	13079	2 sarrett	Z6650 highu	Vau C	pakland	2008 1, ud 21550
	Sta	ate	31. Date filed Month, Day, Year)	32. Régistrar	's Signature	0				-
	Regist	rar	FEB = 5 2	2008	w St	Smarth				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WAYNE **GEORGE** FUNK FEBRUARY 16 2008 11:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Mary Land 1 M 2 □ F 219-26-7214 Director Jan 6. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at Frederick 1 X Yes 2 □ No Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 112 East Second Street 21701 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest Religion 5+and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Funk permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Alfred Clara Lambert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fr Richard Murphy, P.R. 112 East Second Street, Frederick, Maryland 21701 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State St John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Feb 20, 2008 Frederick, Maryland 21. Signatur of Funeral Service Ci 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Postate Concer Physician metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading of innedat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician does detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce

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State Registrar 31. Date filed (Month, Day, Year)
FFB 2 5 2008



o completed cause of death (Item 23a) (Type, Print)

		For State Registrar		.,	Cer	tificate of	Death		Re	eg. No.	.008	0551
Physicia	,),	1. Decedent's Name (First, Middle, La	St)					2	2. Date of Deat Month	h Day	Year	3. Time of Death
/Medic		Maria Soares	Goncalves						ebruary	5,	2008	8:15P M
Examin	er	4a. Facility Name (If not institution, giv 11579 Rest Drive	e street and number)			4b. City, Town, o		of Death		4c. Cou	nty of Death	
		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	thdav)	La P1a		24 Hrs. 8	B. Date of Birth		Char1	es place (State or Foreign
Funeral Director		154-28-2586 Usual Residence of Decedent	□M 2\(\overline{\Omega}\) F		Yrs.	Months Days	Hours	Min.	(Month, Day, uary 11	Year)	Coun	ortugal
/land ow at		10a. State 10b. County		10c. City, Towr	or Lo	cation					1	10d. Inside City Limits
Mary a-f sh	to	MD Char	les	L	a P	lata						1 ☐ Yes 2 No
or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cour	ntry?
ath wi		11579 Rest Driv			-,		2064	<u> </u>			USA	
er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of F f Yes, specify Cub	lispanic Or an, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- ican, etc.)		Race - Americ Black, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene finportant: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:			I□Yes 2√ No	Specify	:		Spe	ecify: Wh:	ite
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filed Hygi other ent, tl		17. Father's Name (First, Middle, Last)		nom	emaker	18. Moth	er's Name ((First, Middle, I	Maiden Suri	Home	
fental rked c	To Be	Manuel Andrade					Ana	Maria	a Da Si	1va		
2 shou and N is mai		19a. Informant's Name/Relationship (ng Address (Street				r, City or To	wn, State, Zip	Code)
and 2 ealth n 27 i		Manuel Goncalves	,Sr. Husbar			79 Rest I	Dr. L			20646		
Pages 1 nent of H int: If iter		20a. Method of Disposition 1 Burial 2 Dermation 3	Removal from State	cemete	ry, crer	sition (Name of matory or other pla	· i	Da		20c. Locatio	on - City or To	own, State
t. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Speci	<i>(y)</i>	4		ld-Echols		2/9/0			tte Ha	11,MD
permir Depar Impor any Ir		21. Signature of Funeral Service Lice	nsee Ehal	100945)	22	AREHART- 211 St.	ECHOL Mary!	"S FUN	ERAL HO	OME,P.	A. D 206	: 1. 6
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do i	not ent	er the mode of dyi	ng, such a	s cardiac or	respiratory arr	est,	**********	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	META	STATI	C	BRAI	w	('n	ME	2		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	-		(1/1)	UCP.			
LXammer	e	Sequentially list conditions,	b	eonsequence	ofik							
nsit	nin	il any, leading to inniediate cause. Enter Underlying Cause (Disease or injury	340 (0, 40 0		w.j.							
execu n and ial-tra	Examin	that initiated events resulting in death) Last	CDue to (or as a	consequence	of):							
rtificate be executed ng physician and as the burial-transit			_d									
rtifica ng ph	Medical	IF FEMALE:								-1		
ath ce ttendii or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1□Live birth	2 Fetal death		⊒Ectopic pregnanc	y			23d.	Date of deliver	very Day Year
that the death ce ed by the attendi detached for use	Physician/	1 Yes 2 No 9 Unknown	4□Pregnant at 9□Unknown	time of death	5 E	Other (specify)					mo.nar	54,
that the the seed by detac		Part II. Other significant conditions	contributing to death bu	t not resulting in	n the u	nderlying cause gi	ven in Part	l.	23e. Did to	bacco use o	contribute to t	the cause of death?
The law requires that the death ce te has been signed by the attendi aage 2 should be detached for use	d by								1 □ Y	es 2 N	to 3 □ Prol	bably 4 □Unknown
law rec as beer 2 shou	Completed								24a. Was a		4b. Were auto	opsy findings available
The la	шо								autop: perfor	sy med? 2.XNo	prior to co death? 1 ☐ Yes	ompletion of cause of 2 □ No
(0 1	Be C	25. Was case referred to medical					26. Plac	ce of Death	(Check only or		10103	20110
hysic his ce I direc	TO E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Ou	utpatier	nt 3□ DOA Ot	her: 4 🗆 N	lursing Hom	ne 5 🕅 Resid	ence 6 🗆	Other (Speci	ify)
Attending Physician: r death. ector: After this certific by the funeral director,	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b.	Time o Injury	Wa			8d. Describe h	ow injury oc	curred	
ttend leath. stor: /	cati	2 Accident investigation 3 Suicide 6 Could not to		in. At home for	arm et	M 1 creet, factory, office	Yes 2	-	9f Logation (C	troot and N	umbar ar Pu	ral Route Number,
l or A after d Direc	Certification:	4 ☐ Homicide determined	building, etc	:. (Specify)	aiiii, Sii	eet, factory, office			City or Tow		amber or num	ar noute teamber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		(Check only edical Exa	hysician: To the best of miner: On the basis of	examination ar								
thin 2 the or the	Medical	29b. Signature and title of certifier	and manner sta	ted.		29c. Licen	se number	,		29d Date si	igned (Month,	Day, Year)
FAFO			LA			N	120	0/		7	1/1/	38
(30. Name and add ss of re on who	completed cause of de	eath (Item 23a)	(Type	Print)	5	00	[1010	<i></i>
BBL			M.D. 12070				Suite	e 207,	Waldo:	rf,MD	20602	
Sta		31. Date filed (Month, Day, Year)		ar's Signature	,	AST						
Registi	rar	rebus	2008 Men	we to	, to	Proceeding.						

			1 - For State Registrar	State of Marylar	•	rtificate of		F	Reg. No. 20	801	05518
	Physici		1. Decedent's Name (First, Middle, Las James Edward					2. Date of Dea Month Februa	Day	Year	3. Time of Death 4:45 a M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			r Location of Death		4c. County	of Death	4.45 a
_	Funeral		Golden Living Cer 5. Social Security Number 6. S		last birthday)	Westn If Under 1 Year	ninster If Under 24 Hrs.	8. Date of Birth		roll 9. Birthol	ace (State or Foreign
	Funeral Director		212–34–4753	MM 2□F 70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug 19,	1937	Mar	yland
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	_	ty, Town or Lo					10	Od. Inside City Limits
	ne Mar 8a-f sh ptiffed	ector	Maryland Carrol	.1			ion Bridg				1XYes 2□No
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notifled at	Funeral Director	10e. Street and Number 26 N. Main Street	:		10f. Zip Code	21791		10g. Citizen of W	Vhat Count JSA	ry?
	er dea items	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 ☐ No	J.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Blace	e - America k, White, e	
CSP	urs aft al", or Examir	by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates: Kore	a	1 ☐ Yes 2 🕱 No	Specify:		Specify	whi	te
9500-612	ר2 ho "natur edical	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor	king	16b. Kind of Bu	siness/Ind	ustry
717	d withis giene. sr than the Ma	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	inc.	Driver			Bus (Compa	ny
yland	uld be file Aental Hyy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Edward L. Gree					ne (First, Middle, erine Mo		,	
, mary	and 2 sho salth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Sharon A. Little,	daughter	PO Bo	ng Address (Street Ox 261, 2	6 N. Mai				
saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifled at once.		20a. Method of Disposition 1 M Burial 2 □Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specif</i>	Hemoval from State		esition (Name of matory or other place Forest V		Date 2/2008	20c. Location - Owings	•	
משב	permit. Departr Importa any inje	_	21. Signature of Funeral Service Licer	1000		2. Name and Addre					
ES			23a. Part . Enter the disease, or com short, or heart failure. List only	plications that caused the dea					-		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	.a	1514	0					Onset and Death 5 YEARS
	Examiner			Due to (or as a consec	quence of):						
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
,	death certificate be executed e attending physician and d for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consec	quence of):						
68/60 ,	ate be hysicia he bur	l edical		.d							
	certific iding p	/Mec	IF FEMALE:	23c. If yes, outcome pf pregn	nancy	———————————————————————————————————————			22d Dat	e of deliver	
.C. BOX		Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		Mo		Day Year
S,	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.			_	e cause of death?
000	requir	eted			***				es 2□No	Marie Control	ably 4 □Unknown
Ū T	The larate has	Completed						24a. Was a autop perfor	sy med?	orior to con d <u>ea</u> th?	osy findings available opletion of cause of 2 No
<u> </u>	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	oth		th (Check only or			
101	ding Physiclan: n. After this certific funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			ome 5 ☐ Resid 28d. Describe h	ow injury occurr		")
SION	ttendlr death. tor: Af	catio	1∕☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1□	Yes 2 □ No	Oof Lanation (C	Name at a send \$1, send		I Davida Maraha
2	al or A s after o	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ify)	eet, factory, office		City or Tow	itreet and Numb n, State)	er or Hurai	Houte Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier T Certifying Ph (Check only one) 2 Medical Exar	ysiclan: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the dirred at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
		Me	29b. Signature and title of of differ	1 a lat	- M	29c. Licens		:	29d. Date signe	d (Mony), I	Day, Year)
}	WIL		30. Name and address of person who	completed cause of death (the	m 23a) /Tun-		59172		2/3	/ del	
	W, 10		CU UMSHANMAN	C. MAGANN	7 700	A Pool	e perso	UESM.	N STEL	mo	21157
- 2	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6	32. Regierar's Sign	ature	how.					
	3		1 1 1 0 0	2000	15	STANGE !					

08-01268 Nathan Gowen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

tnan Gowen		State of Maryland / Department - For State Certificate		ygiene Reg.	200	8 05519
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Nathan Adam GOWEN		2. Date of Death Month February 13		3. Time of Death 2131 hrs
, l		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral		Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Takoma Park If Under 1 Year If Under 24Hrs	8. Date of Birth	Montgomery MM/DD/YYYY) 9. Bir	thplace (State or
Director		017 00 7005	Yrs. Months Days Hours Min	Dec. 3,	1966 Foreig	ountry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
Z A faryland 28a-f show	ţō	Maryland Prince Georges Adelph	10f, Zip Code	1100	. Citizen of What Cou	1 Yes 2 X No
the Mar is or 28a	Director	2606 Lackawanna Street	20783		United Sta	
L (ath with items 23	uneral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,
safter de ral", or	by Fu	or Dates:	Yes 2 No specify:		Specify:	ite
72 hours n "natu	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation (Give kind of g most of working life, DO NOT use ret		6b. Kind of Business	Industry
-0036 I within grene. ther tha	Completed	17. Father's Name (First, Middle, Last)	er Worked	e (First, Middle, Ma	None	
1215. I be filed ental Hy irked of	Bec	Thomas Gowen Jr.		e (First, Middle, Ma e Miller		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other reaumatic event, the Medical Examiner must be notified at once.	ြို	19a. Informant's Name/Relationship (Type, Print) Jessica Lillienfeld, Sister 96	illing Address (Street and Number or 5 Main Street, Ga	Rural Route Numb i thersbur	er, City or Town, State 'g , MD 208	e, Zin Code) 378
Ore, Lose I and of Healt International		1 X Burial 2 Cremation 3 Removal from State crematory o	position (Name of cemetery, rother place)		20c. Location - City o	
altimomit. Pagariment			emorial Gardens (2.Name and Address of Facility Torchinsky Hebrew	02/21/08	Olney, I	MD
		23 Part. Enter the disease, or complications that caused the death. Do not ent	25/1 Carroll St.	runerai NW. Washi or respiratory arres	naton, DC t. shock or hear	20012 proximate Interval
Physician /Medical 		failure. List only one cause on each line. Immediate Cause (Final disease a. Ai razolam and Oxycola				Between Onset and Death
	ı	or condition resulting in death) Due to (or as a consequence of):				
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter the property in Course or injury that iditated				
xecuted n and - transit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
9 E E	Medical	UNPENDED X AMENDED 23a, 27, 28a-f p	er ME g877 03/14/2008	amh		
OX 68760, ath certificate be exattending physician for use as the burial.	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr		23d. Date of delive Month	ry Day Year
Box ie death c the atten ted for us	≥	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Unknown	Other (Specify)		100	1
ecords, P.O. Box 68760, he law requires that the death certificate be ate has been signed by the attending physicis are 2 should be detached fro use as the burit.	\$	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.			o the cause of death?
Division of Vital Records, tal or Attending Physician: The law require stander death. al Director: After this certificate has been sifed in by the timeral director, page 2 should be in by the timeral director, page 2 should be	Completed			24a. Was a autops	y prior to	autopsy findings available completion of cause of
ე_ი	Com	OF Wassessels and to add to	26 Place of Death (Checi	perform 1 Yes 2		
Vital Vital hysician this cert	e Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: Inpatient 2 ✓ ER/Outpat	TOther:		Residence 6 Oth	er:
lof ling Ph	<u>ا</u> ا	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		28d. Describe he	ow injury occurred	
Sion Attend death. ctor:	atic	2 Accident Investigation 2/13/2008 found	8:50 pm 1 Yes 2 XX No	unknown		Davida Niverban City
Division / urs after real Dire	Certification: To	3 Suicide 6 XX Could not be 4 Homicide 6 XX Could not be determined (Specifyfound at residen		or Town, St	ate)	Rural Route Number, City , Beltsville, MI
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o one) 2 Medical Examiner: On the basis of examination and/or inves	ccurred at the time, date and place, ar tigation, in my opinion, death occurred	nd due to the cause at the time, date a	e(s) and manner as stand	ated. the cause(s)
To To	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
		Joisha Gely un	O.C.M.E.		February 14, 20	008
		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, M	ND 21201		
Regi	State					

State

Registrar

31. Date filed (Month, Day, Year)

FEB 11

2008

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 20<u>08</u> **Physician** February 8:25 Carl Lee Groft, Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Carroll Hospice Dove House 8. Date of Birth (Month, Day, Year) Feb 19 1957 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 50 Maryland Director 216-66-1510 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 XNo Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21074 1961 Albert Rill Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1975 — If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: ģ White 3 Widowed 4X Divorced Year or Dates: 1978 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Master Service Technician HVAC es 1 and 2 should be filed vol Health and Mental Hygie fitem 27 Is marked other I rother traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any Injury or other trauments. Ruby Virginia Lyons Charles W. Groft. Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD Carl L. Groft, Jr. Son 4401 Geeting Rd. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 2/7/08 Hampstead, Maryland 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Sto **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 0. the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be d Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 t certificate 1□ Yes 2 N Vital Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Doubler (Specify) 1 Yes 2 V 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To 0 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Howc After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director; A
filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ense number 54218 29d. Date signed (Month, Day, Year) 02-07-08 29c. License number 29b. Signature WIL Malcalm dure, West mingen MD 2/137 IOHVA 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaneva,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Malus

2008

			1 - For State Registrar	State of Maryland		ate of Dea			g. No.2	08	05522
			Decedent's Name (First, Middle, Last)				2	2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		JOSEPH CARLISI	LE GREER, JR.					16,20		6:05A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. (City, Town, or Loca	ation of Death		4c. Cour	ty of Death	
			CHAS.CO.NURSING				PLATA		CHAR	LES	
a.	Funeral		5. Social Security Number 6. Sex	LM 2∏F	Mon			B. Date of Birth (Month, Day,		9. Birth	place (State or Foreign ntry)
主	Director		311-40-1233	81	Yrs.		N	IOV.8,	1926	MD.	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location						10d. Inside City Limits
	Mary	ō	MARYLAND CHARLE	ES	I	A PLATA	4				1 XYes 2 No
	288.	Director	10e. Street and Number		101	. Zip Code		1	0g. Citizen o	f What Cou	intry?
	3a or		10200 LA PLATA	ROAD		20646	5	Į	U.S.A	•	
	death ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was D	ecedent of Hispan specify Cuban, Me	ic Origin? (Spec	ify Yes or No-		ace - Amer	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "nature!", or Items 23s or 28s-f show ent, the Macical Exemple must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		_	ecify:	ican, etc.)		lack, White ify: WH	
ğ	2 hou	ted	15. Decedent's Edu	cation	16a. Decedent's	Usual Occupation			16b. Kind of	Business/li	ndustry
2	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life. DO NO	f work done during T use retired)) most of working		MD. S		
7	filed within I Hygiene. Other than	0	8th		FOREM	IAN			HWY.A	DMIN	•
ם	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)			18.	Mother's Name (First, Middle, N	Maiden Sum.	ame)	
<u>ya</u>	should be nd Mental nmarked umatic ev	2	JOSEPH C. GREE	ER, SR.			KATIE M	-			
Maryland	2 6 5		19a. Informant's Name/Relationship (Ty			ress (Street and N					
0	1 end Health Ism 27 other tr		FLORENCE GREER- 20a. Method of Disposition		7475 PC		Da		20c. Location	•	20693
0	if its		1 ☐Burial 2 ☐ Cremation 3 ☐ P	emoval from State	emetery, crematory	or other place)	l I				
Ë	t. Pa rtmer rtant		4 Donation 5 Other (Specify)		TY MEM.				WALDO		D.
Baltimore,	permit. Pages 1 en Department of Heal Important: if item 2 eny injury or other once.		21. Signature of Funeral Service License	™ M00479	RAY	e and Address of MOND FU	NERAL	SERVI	CE,P.	Α.	
	80		23a. Part1. Enter the disease, or compli	cations that caused the death		PLATA, M			est		Approximate
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	+	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	alex	ninkla				,		
	Examiner			Due to (fr as a consequ	nentiquence of):	Carde	1m ren	6	hora	20	
40	类。第一	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	Jence of):	, oran	o o que una	an a		20	
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o.	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
68760,	licate be executed physicien and s the burial-transit	edical		J							
9			IF FEMALE:								
Вох	ath certif attending for use a	an/	23b. Was decedent pregnant	3c. If yes, outcome of pregnal 1 Live birth 2 ☐ Fetal		oic pregnancy				Date of deli-	very Day Year
	e dea he at hed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown	eath 5 🗆 Othe	r (specify)				VIO: HIT	Day Teal
0	es that the death cer igned by the attendin be deteched for use	Physician/M	9 Unknown		.ht1		D-AI	220 Did to	haaaa	nateibuta ta	the cause of death?
S,	The law requires that the death certif ate has been signed by the attending page 2 should be deteched for use a	Ď	Part II. Other significant conditions cor	imputing to death but not rest	nang in the underly	ing cause given in	raiti.		es 2 \square No		
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9	e law has t	Ig II						24a. Was a autops perform	y	b. Were aut prior to c death?	opsy findings available ompletion of cause of
~	age age	Ö						1 ☐ Yes	2 10 No	1 🗆 Yes	2 No
a B						Othor	Place of Death				
Vital R	sicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	maria III ca	1 DOA 4	Nursing Hom	e 5 🗌 Reside	ance 6 (C		
Vital	Physicien: The this certificate hiral director, page	To Be	examiner? 1 Yes 2 No		ER/Outpatient 3[28b. Time of	- 1		3d. Describe ho			iry)
of Vital	ding Physicien: n. After this certification of the director.	To Be	examiner? 1 Yes 2 No F	lospital: 1 Inpatient 2 Inpati	ER/Outpatient 35 28b. Time of Injury	28c. Injury at Work?	28	Bd. Describe ho			iry)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** a^{M} February 6 2008 2:55 Betty Jane Hesson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🔀 F July 31 1928 Director 220-28-2768 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Ħ 1 ☐ Yes 2 ☐ No irai", or items 23a or 28a-f st Examiner must be notified MD Carroll Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2039 Frizzellburg Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: \$ 3 Widowed 4 ☐ Divorced White "naturai" Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Kelly Stationery es 1 and 2 should be filed wi of Health and Mental Hygier f item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Luella Martin 2 John Richard Kerr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15 Middle Grove Ct., Westminster, MD Linda Hesson/daughter permit. Pages 1 al Department of Hea Important: if item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/08/2008 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 Donation 5 Dother (Specify) Printend Fune Mal Home and Chapel, P.A. 21. Signature of Funera Toul 412 Washington Road Westminster, MD 21157 23a Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Imo disease or condition resulting in death) /Medical Examiner cular Accident rebral sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and -trans Due to (or as a consequence of) the burial Box 68760. physician Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No - has page certificate 1□ Yes 2 Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident Injury 5 Pending

funeral director. Division or After this Hospital or Attending death.

within 24 hours after death To the Funeral Director; completely filled in by the f

WSL 10

(Check only one) 29b. Signature and title of certifier

investigation

6 Could not be determined

HUBME

30. Name and address of person whe

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Kimberly Johnston, M.D.

Westminster

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 2008

Registrar

		•	For State Registrar	State of Mary		artment of H ertificate of L		ental Hyglen e Reg. No		
0			Decedent's Name (First, Middle, Las	t)				2. Date of Death Month Da		3. Time of Death
	Physici /Medic		CLARENCE	HILDEBI	RAND	3	F	EBRUARY	06,2008	5.00 M
	Examin	-	4a. Facility Name (If not institution, give				Location of Death	1	County of Death Baltimore	
			Northwest Hospit		yrs. last birthday			Date of Bloth	0.8145	
	Funeral Director		5. Social Security Number 220-01-3022 Usual Residence of Decedent	9X 7. Age (/// 8)		Months Days	Hours Min.	(Month, Day, Year) 12/11/192	20	ace (State or Foreign try) MD
	land ow	-	10a. State 10b. County	100	c. City, Town or L	ocation.			10	Od. Inside City Limits
	Mary -f sh	ţo	MD Baltimo	re	Woodsto	ck				1 ☐ Yes 2 🙀 No
	th the	Director	10e. Street and Number			10f. Zip Code		10g. Cit	izen of What Coun	try?
	23a c		3110 Hernwood Rd	•		21163			USA	
98	be filed within 72 hours efter deeth with the Maryland ital Hygiene. id other than "naturel", or iteme 23a or 28e-f show event, the Madical Examiliar Court of the Incillian at	y Funeral	11. Marital Status 1 ☐ Never Married 2√2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1944-	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√2 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, of Specify: Whi:	etc.
21215-0036	hours turei	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates: 194	40	edent's Usual Occupa	ation	16h K	ind of Business/Inc	
15	n "na	Completed	(Specify only highest gra	de completed)	(Giv	e kind of work done of DO NOT use retired	turina most of working	7	and of pasities with	ustry
212	filed withii Hygiene. other than ent, Ine M	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Ra	ilroad Eng	jineer	В 8	O Railro	oad
pu	ihould be filed withir ind Mental Hygiene. marked other than matic event, Ing M.	Be C	17. Father's Name (First, Middle, Last)					First, Middle, Maider	Sumame)	
ylaı		2	Clarence A. Hi				Elsie T			
Maryland	2 2 2 3	0 3	19a. Informant's Name/Relationship (7		1			Route Number, City o		Code)
		1	Doris Mathena/Da 20a. Method of Disposition			Oosition (Name of	ave., wood	stock, MD	ZIIO3 ocation - City or To	wn State
Baltimore,	Pages nent of int: if if		1 Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	1	cemetery, cre	ematory or other plac			odstock,	
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Liasen	ally				l Home & Rd., Winf		
			23a. Part1. Inter the disease, or compshock, or heart failure. List only	plications that used the one cause or each line.	death. Do not er	nter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Pnysician :		Imme lat: Cause (Final disease or condition resulting in death)	45	MARY	ARTER		EASE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor		1.11.				~
	Lxammer		Sequentially list conditions,	b	DAKH	LE I	SEME	AITH		AND THE RESERVE
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a cor		and the second second	Overtin	There		
	xecul and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a cor		ETES	Meth	102		
68760,	icate be executed physicien and s the buriat-transit		•	d						
.89	tificati g phy as the	ledical								
Вох	eath certific attending p	M/Ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		□Ectopic pregnancy			23d. Date of delive	-
.O. E	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
Δ.	thet ti		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Records,	uires sign	d by						1 □ Yes 2	No 3□ Prob	ably 4 Dunknown
Ö	w requires been si	Completed						24a. Was an	24b. Were auto	psy findings available
Be	The lav	omp						autopsy performed?	death?	mpletion of cause of
Vital		0	25. Was case referred to medical				26. Place of Death		, , , , , , , , , , , , , , , , , , , ,	
>	si si	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Othe	er: 4 🗌 Nursing Hom	e 5 🗆 Residence	6 ☐Other (Specify	1)
n of	ng Ph (fter th uneral		27. Manner of D ath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time Injury	Work	ς?	3d. Describe how inju	ry occurred	
Sio	of the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	of Leasting (Ctrast a	ad Alumbos os Rum	I Pauta Numbar
Division	or A after Dire in b	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, s pecify)	treet, factory, office	21	3f. Location (Street a. City or Town, State		r Moute Number,
	To the Hospitel within 24 hours a To the Funerei I completely filled	Medical		ysician: To the best of my niner: On the basis of exa and manner stated.						
	To the within 2 To the complet	M	29b. Signature and title of certife	20 11	No. 15	29c. License	number		ate signed (Month,	
)	hoo		De Sugar of	111-chla	W.0	DI	11410	Feh	rusky o	6,2018.
1	NAK		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) JoG	INDERP	MEHT	A . 1	
5	7		MORTHWEST H	05P17DL CE	ENTER		WOTOW		2115	33.
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 7 20	08 Registrar's S	Signature	arti				

			For State Registrar	State	of Marylar		artment <i>rtificate</i>			and Me	ental Hy	giene Reg. No.	2008	05525
			Decedent's Name (First, Middle	le, Last)							2. Date of De	eath		3. Time of Death
	Physici /Medio		Rex Allen Harri	Lson							Month Februa	ry 7	, 2008	8:33 A M
	Examir		4a. Facility Name (If not institutio	n, give street and i	number)		4b. City, To	own, or	Location o	of Death			County of Dea	ath
100			21514 Coopertov		1		Tilgh		If I ledox	O4 Llas T			lbot	
	Funeral Director		5. Social Security Number 216-70-7256	6. Sex 1 🛣 M 2 □ F	7. Age (In yrs.		If Under 1 Months	Days	If Under	Min.	8. Date of Bii (Month, Da Mar 18	th ay, Year) • 195		irthplace (State or Foreign Country) Yland
	land bw		Usual Residence of Decedent 10a. State 10b. County	,	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	he Mary 18a-f sh otifled a	Director	Maryland Talbo	t	Ti1	ghman	1					40 00		1 Tes 2 No
	with the or 2 the n		10e. Street and Number 21514 Coopertow	m Poad			10f. Zip 0					USA	zen of What C	country?
	ns 23	Funeral	11. Marital Status	12. Was D	ecedent Ever in U	J.S. 13.			spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)		14. Race - Am	nerican Indian,
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notifled at	by Fur	1X Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Ye If Yes,	Forces? s 2 XNo Give Dates:		If Yes, specil 1 ☐ Yes 2		Specify:	i, Puerto F	Rican, etc.)	1	Specify: Wh	•
21215-0036	72 hou natura Ilcal E	Completed	15. Deceder (Specify only highe	nt's Education	d)	16a. Dece	dent's Usual	Occupa	ition	t of workin	a		nd of Busines	
218	ithin 7 ne. nan "r e Med	nple	Elementary/Secondary (0-12)	<u> </u>	e (1-4or 5+)		kind of work DO NOT use				g			
121	lled w lygier her th		12 17. Father's Name (<i>First, Middle,</i>	/ not)		Comme	rcial				(First, Middle	Seaf		
Maryland	d be f ental h ced of	o Be	Herman Reeser H	*								*	Cummir	ngs
ary	shoul and Me mark umati	ပ္	19a. Informant's Name/Relations			19b. Maili	ng Address (r Town, State,	
Ž	and 2 salth e		Herman Jeffery	Harrison	/brother	2140				ilgh:	man, M	D 216	571	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 Burial 2 XCremation		m State	Place of Dispo cemetery, cre					ate		cation - City o	
ij			4 □ Donation 5 □ Other (5	Specify)	Ch	esapea							sville	
Bal	permit Depar Impor any in		21. Signature of Funeral Service	Hentle	e MO									Box 784 lle, MD 2102
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause of	at caused the deat n each line.	th. Do not en	ter the mode	of dying	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		astatic		Cancer							1 year
1	/Medical Examiner		resulting in deathy	Due	to (or as a consec	quence of):								
	(M-1)	- e	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a consec	quence of):								
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	C.										
0,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due	to (or as a consec	quence of):								
8760,	cate b	dical		d										
9	certific ding p	/Me	IF FEMALE:	23c. If yes.	outcome pf pregn	ancv							Old Date of d	alivan
Box	law requires that the death certifics as been signed by the aftending pf 2 should be detached for use as It	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Liv	e birth 2 Feta	al death 3[⊒Ectopic pre ⊒ Other <i>(spe</i>					2	23d. Date of d Month	Day Year
0	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		known			-						
S, P	ires that the de signed by the a be detached	by P	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	inderlying cal	use give	n in Part I.	٠	23e. Did	tobacco u	se contribute	to the cause of death?
ord	w require been sig should b	ted t									1 🗆	Yes 25	∑No 3□1	Probably 4 ☐Unknown
Records,	has be	Completed									24a. Was	psy	prior to	autopsy findings available o completion of cause of
표	Th ate pag	ပ္ပြ									1□ Yes	ormed?	death1 1 ☐ Ye	es 2 No
or Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo	Hoepital:		TED/Outratia		Othe			(Check only			
ō		1: To	1 Yes 2XXNo 27. Manner of Death	28a. Da	ite of Injury	ER/Outpatie		c. Injury Work	4 🗆 Nu		ne 5/13/ Res 8d. Describe		Other (Sp y occurred	pecify)
<u>io</u>	Attending r death. ector: After by the fune	ation	1X Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (M igation	lonth, Day Year)	Injury	м		? ⁄es 2 🔲	No				
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd Zoe, Fla	ace of injury - At hilding, etc. (Speci	ome, farm, st	reet, factory,	office		2	8f. Location (City or To	Street and	d Number or i	Rural Route Number,
	pital o		29a, Certifier **Certifyl	ng Physician: To	the best of my ke	owledge deat	th occurred a	t the tim	o data ar	nd place a	and dup to the	2 201100(0)	and manner	as stated
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one)	I Examiner: On the	e basis of examination anner stated.	ation and/or ir	nvestigation,	in my op	oinion, dea	ath occurre	ed at the time	, date and	l place, and d	ue to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certific	er —	2/-	~	29c.	License	number			29d. Dat	e signed (Mo.	nth, Day, Year)
			> will	ain	The		D43	3238				Febr	uary 7	, 2008
(300		30. Name and address of person William Bair, N					ge,	MD 21	1613				
	Sta Registi		31. Date filed (Month, Day, Year FEB 1		. Registrar's Sign		barle							
					- Beer Visitor Street	13.	MALL							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05526

hysicia Exami		Registrar				· ·····outo	of Death					Reg. No				
		Decedent's Name (First, Mid					-			1	Date of D Month Februar	Day	NR Year			
		Jason David H. 4a. Facility Name (if not instituti			ımber)		4b. City, To	wn, or Lo	cation of		Coloai		c. County o	f Death		
	*	Shady Grove Hospita	al				Rockvi	lle					Montgor			
ineral		5. Social Security Number	6. Sex		7. Age (In yrs. I	last birthday)	If Under		If Under Hours	24Hrs. Min.	8. Date of	Birth(MM	VDD/YYYY)	9. BirthForeign		e or
rector		212-80-9586	1 X N	M 2 F	3.	3	rs.	Days	Hours		Jun <u>e</u>	11,	1974	Cou	In Birthplace (State or oreign Country) Maryland 10d. Inside City Limits 1 Yes 2 X No Country? American Indian, Black, etc. hite less/Industry Training State, Zip Code) Tryland 21774 Styring, Maryla Funeral Home and 20872 Approximate Interval Between Onset and Death	
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ental I urked vent,	å	Paul David Had						C	arol	Sus	an Mu	ısseı				
is ma	유	19a. Informant's Name/Relation		,		1										
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Paul David Ha	<u>leed</u>	, fath			2 Barn				<u>New</u> Date					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:55p M Rosemarie Hickey February 5, 2008 Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11510 Rokeby Avenue Kensington Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 T F Director 578-46-3715 76 3, 1932 Washington, Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nnt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shor dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11510 Rokeby Avenue 20895 IISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💃 No Specify Specify: White 3√√Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Jeremiah Kelly Rose Natalie Fratantuono if item 27 is marke or other traumatic ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin R. Hickey/Son 5208 Gretchen Street, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9, Feb. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Puneral Service Livensee Francis J. Collins Funeral Home Inc. wherd I Haleo 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performed? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Ari Fishman, MD

FEB 08 2008

31. Date filed (Month, Day, Year)

d32864

5530 Wisconsin Avenue, #1125, Chevy Chase, MD 20815

February 7, 2008

08-01391		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legi	ble.	
Jimmy Anthony 2		State of Maryland / Department of Health and Mental H 1-For State Certificate of Death		200	18 05528
Physicia		Registrar	Reg. 2. Date of Death	No.	3. Time of Death
Medical Examin		Jimmy Anthony Zavala Hernandez	February 17)ay Year 7, 2008	1347 hrs
oral in		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	1
		441 West Side Drive Gaithersburg	Doto of Birth	Montgomery (MM/DD/YYYY) 9. Bir	thniaco (State or
Funeral Director		5. Social Security Number none 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir		Foreig	gn El Salvador ountry)
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		Maryland Montgomery Silver Spring			1 Yes 2 X No
200 larylar at on	Director	Maryland Montgomery Silver Spring 106. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	intry?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once.		3138 Hewitt Avenue, Apt. 120 20906		El Salvad	or
h with	Funeral	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
r deat or ite	Fu	1 Yes 2 X No		Specify: W	hite
rs afte ural",	þ	3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No specify: Sci. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	
2 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re	tired)		
036 ithin 7 ne. r than	ď	1 Bus Boy		Restaur	ant
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121 d be fi lental arked event,	Be	Fidel Antonio Zavala Isi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		el Hernand	
D 2 shoul and M 7 is m	မ	Lucia A. Mariona/Aunt 3138 Hewitt Avenue, Apt			
and 2 and 2 fealth item 2 traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City o San Ram	r Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) San Ramon, Mejicanos	· i	El Salv	· .
Baltin permit. Pa Departmen Importan injury or		4 Donation 5 Other Specify: 21. Significant of Funeral Services Licentee 22. Name and Address of Eacility Francis J. Collin	008		
Dep Dep Inju		Michelle Wormon 500 University B1	vd., W.,	Silver Sp	ring, MD 2090
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Acute alcohol intoxication			Death
, xummer		or condition resulting in death) Due to (or as a consequence of):			
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Chisease or injury that initiated	·.		
and transit		events resulting in death) Last Due to (or as a consequence of):			
executor an and al - tran	ical	X UNPENDED			
1760, ficate be exe g physician a	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	-	23d. Date of delive	ery
Box 68760, e death certificate be the attending physic ed for use as the bur	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregu	nancy	Month	Day Year
OX 687 eath certific	/sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		24	
b.O. E that the d ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
ires that signed	d by	Atherosclerotic cardiovascular disease	1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
Division of Vital Records, P. tal or Attending Physician: The law requires the safter death. al Director: After this certificate has been signe led in by the funeral director, page 2 should be d.	Completed		24a. Was a		autopsy findings available is completion of cause of
eco ne law te has ge 2 s	gmo		perform	ned? death?	
tal Rec cian: The certificate		25. Was case referred to medical 20. Place of Death (Chec			
Vita hysicia this ce	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Cutpatient 3 DOA Other 4 Nurs	sing Home 5 F	Residence 6 🗸 Oth	ner: Scene
n of ding Ph	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
trendi leath. tor:	atio	Natural 5 Pending Pending Investigation Fnd 2/17/2008 FNd 12:00 pm 1 Yes 2 No	unk		
Division Hospital or Attene 24 hours after death Funeral Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, St	ate)	Rural Route Number, City
D Spital hours meral y fille		4 Homicide Tourid III House			thersburg MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, all cone) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date a	and place, and due to	the cause(s)
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
3 PEND	_	Day O Pago A O.C.M.E.		February 18, 2	008
		30. Name and address of person who completed cause of death (Item 23a)		L	
_		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltime	оге, MD 21201		
	tate	■ ■ ■ ■ Z. 11 /1111X ASSET = Z.			
Regis	trar	FEB 2 0 2008 Beautiful St Appendix			

OCME

08-01002 Donald J. Hough

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

maid of Floogr		I- For State	os iviai yiand / D	Certifica			ia ivioin	iai i iye		. No. 21	JUE	3 0552
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)						2	. Date of Death	Day Year		. Time of Death
edical Exami	ner	Donald James Houg	<u> </u>			b. City, Town, c	al antina		February 4,	2008 4c. County of		1221 hrs
		 Facility Name (if not institution, give 3825 McDowell Lane 	street and number)		4	Halethorpe		Death		Baltimore		ty
Funeral		Social Security Number 6. S	7. Age (In	yrs. last birtho	lay)	If Under 1 Ye	ar If Unde	r 24Hrs.	8. Date of Birth	(MM/DD/YYYY)		place (State or
Director		216-30-7745 1X	M 2 F	75	Yrs.	Months Da	ys Hours	Min.	9/24/1		Foreign Coun	itry) MD
,		Usual Residence of Decedent			. (4)						11	0d. Inside City Limits
bw an		10a. State 10b. County MD Anne Art:		City, Town or								1 Yes 2 X No
ryland a-f sh	횽	MD Anne Aru	indei	Haleth	orp	e 10f, Zip Code			10:	g. Citizen of Wha		
ith the Maryland 23a or 28a-f show any notified at once.	Director	3825 McDowell Lan	ie				21227			USA		
with t ns 23a be not		11. Marital Status	12. Was Decedent Eve	er in U.S.		s Decedent of F						an Indian, Black,
death or iter	Funeral	1 X Never Married 2 Married	Armed Forces? 1 Yes 2			es, specify Cub			ican, etc.)			
rs after ural", miner	ρ	Widowed 4 Divorced Divorced Specify on	If Yes, Give Year Viet or Dates:			Yes 2X N			rk done	Specify: 16b. Kind of Bus	Whi	
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036 ithin 7 me. r thar	ā	12			•	Electri						ation
15-0 filed w Hygic d othe		17. Father's Name (First, Middle, Last) Harry Edgar Hough							First, Middle, M Veber Ja	aiden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	To Be	19a. Informant's Name/Relationship (Ty		196.	Mailing	Address (Str				oer, City or Town	n, State,	Zip Code)
MD d 2 shot If th and is 27 is 18 aumatic		Nancy Cowain	Sister	9		Country			ord, Te		021	
re, rand Thealt Fitem		20a. Method of Disposition 1 Burial 2 Cremation 3	Romoval from State			ition (Name of one of o	emetery,		Date	20c. Location -	City or T	own, State
Pages nent of ant: I or oth		4 Donation 5 Other Specify:		Metro		ematory			2008	Baltimo	re,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand and Montal Hygiers in the Maryland Insportment. If item 21 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Futheral Service Licens	søl			lame and Addre		паг		uneral		, P.A.
Physician		23a. Part I. Enter the disease, or compl	lications that caused the	death. Do not	112 enter th	Ridge1	y Ave. g, such as c	An	napolis respiratory arre	st, shock, or hea	401 art	Approximate Interval
Medical		failure. List only one cause on ea	^{ch line.} Hypertensive Athe								J	Between Onset and Death
caminer			Due to (or as a consequ									
	ᇦ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):	_							
	Examiner	cause. Enter Underlying Cause										
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760, cate be ex physician the burial	≥	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy						23d. Date of		W
Box 687 death certific the attending p	sician/	past 12 months?	1 Live birth 4 Pregnant at tim	e of death 5		tal death (Specify)	3 Ectopi	ic pregnan	icy	Month	Da	ay Year
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Records, The law require ficate has been si	Completed								autop: perfor	m <u>ed</u> ?	death?	ompletion of cause of
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical				26 Pla	ice of Death	(Check o	1 ✔ Yes	2 No 1	✓ Ye:	s 2 No
of Vital ng Physician: After this certi	Be c	_	lospital: 1 Inpatient	2 ER/Ou	tpatient		Other 4			Residence 6	✓ Other:	: Scene
of \ ing Phy After th	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,Year	28b. T	ime of I		njury at Wor	_	28d. Describe h	now injury occurr	ed	
tendi teath.	atio	1 ✓ Natural 5 Pending 2 Accident Investigati				1_	Yes 2				- 1	
Division tal or Attendians after death.	Certification:	3 Suicide 6 Could not determine		y - At home, fa	rm, stre	et, factory, offic	e building, e	etc.	28f. Location (S or Town, S		er or Rur	ral Route Number, City
lospita 4 hours unera	S	29a. Certifier	ian: To the best of my ki	nowledge, dea	th occu	rred at the time.	date and p	lace, and	due to the caus	e(s) and manner	r as stat€	ed.
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F % F %	Me	29b. Signature and title of certifier					ense numbe	г		29d. Date sign	•	
	1 3	U tuntule	ery)			0.0	C.M.E.			February 5	, 2008 ———	
W. AL		30. Name and address of person who Laron Locke MD. Assis	complete trause of dea tant Medical Exam		Penr	n Street, Ba	Itimore, N	ИD 2120	01			
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		_	For State Registrar	State o	f Marylan		artment of F rtificate of			lental Hygi	. 2	008	05531	n
	-		Registrar 1. Decedent's Name (First, Middle	. (ast)			tineate or	Death		2. Date of Death	j. No. 🚄	000	3. Time of Death	
	Physicia	an	Rosemarie Hu							Month Februar	Day	2008	2:57 P M	
	/Medic	44.00	4a. Facility Name (If not institution		mber)		4b. City, Town, o	or Location	of Death	1 ebi uai		unty of Death	2.5/ 1	_
)	Examin	er	Anne Arundel	_			Annar					e Aruno	le1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign	7
	Director		199-32-8376	1 □ M 2 🖁 F	65	Yrs.	Months Days	Hours	IVIII.	11/27/1	942		nsylvania_	
Н	p ,		Usual Residence of Decedent		100 Cit	y, Town or Lo	nation						10d. Inside City Limits	_
	aryla show	_	10a. State 10b. County	A 1 . 1	100. 011								1 ☐ Yes 2 📆 No	
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	a or 3	ă	2541 West Cou	cse Dr.			1	L401		"	-	SA		
	within 72 hours after death with the Maryland lene. I than "matural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U	.S. 13. ¹	Was Decedent of	Hispanic Or	rigin? (Sp	ecify Yes or No-		Race - Ameri	can Indian,	_
_	fter d r iten niner	Fun	1 ☐ Never Married 2 → Marr	ied Armed Fo	2 TNo		If Yes, specify Cul	ban, Mexica	n, Puerto	Rican, etc.)		Black, White,	etc.	
2	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D			1 ☐ Yes 2 🛣 No	Specify:	:		Sp	ecify:	White	
215-0036	72 ho natur lical	Completed	15. Deceden (Specify only higher	's Education		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of work	ina I	16b. Kind of Business/Industry			
7	ithin ne. nan "	Jqr Be	Elementary/Secondary (0-12)	College (1-4or 5+)			ed)				**		
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/land	ild be fi fental H rked ot tic ever	B	17. Father's Name (First, Middle,	s Labusky				1		Zupkie	alderi Gu	mame)		
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Mar	d 2 sho th and t7 is mo trauma		Roy R. Hutteman		d					Annapol	•			
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Baltimore,	permit. Page Department (Important: If any Injury or once,		21. Signat of uneral Solice		Ru.		2. Name and Addr	ress of Facil		orge P.				
ñ	Deg any		Illutte Ill	le-			2973 Sol	omons		ind Rd. E				
2	10.0		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not en	ter the mode of dy	ing, such as	s cardiac	or respiratory arre	st,		Approximate Interval Between	
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ň	atter for u	iciar	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2□Feta nant at time of o		⊒Ectopic pregnan ⊒ Other <i>(specify)</i> .	icy				Month	Day Year	
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Division or	or At after of Direction by	Certification:	4 ☐ Homicide detern	ined Zoe. Flac build	ding, etc. (Speci	ify)	reet, factory, office	е		City or Town	, State)	vuiliber of Au	ral Route Number,	
	spital ours a leral filled		29a. Certifier 1 ertifyli	ng Physician: To th	e best of mv kn	owledge, dea	th occurred at the	time, date a	and place	, and due to the ca	ause(s) a	nd manner as	stated.	
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	0	, <u>}</u>	30. Name and address of person	~ M)			$\mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} $	317	てナ		02	106	108	
7	4.00	'n	30. Name and address of person	who completed car	ise of death (Ite	m 23a) (Type	Print)				1	-		
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State Registrar 31. Date filed (Month, Day, Year) FEB 0 7 2008

Douglas Haw Mand Jr. Baltimore. Marvland 21215-0036

κ 68760,
P.O. Box
Records,
of Vital
Division

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		For		State of Ma	aryland /				and Mental H	ygien	100	05531	
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ges 1 and 2 should be filed within 72 hours after death with the Manyland to Health and Mental Hydiene. It flem 27 is marked other than "naturel", or iteme 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married	12. Was Decedent Armed Forces? 1 Types 2 If If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:						erican Indian, te, etc. hite	
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tel or Attenos safter deatl	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	farm, str	eet, factory, office			(Street a		lural Route Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director; a completely filled in by the fa	edicai	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exan	y sician: To the best on niner: On the basis of and manner sta	examination a	lge, deat and/or in	h occurred at the tim vestigation, in my op	ne, date a pinion, de	nd place, and due to that ath occurred at the time	ne causei e, date a	(s) and manner a ind place, and du	is stated. e to the cause(s)	
To the com	Σ.	29b. Signature and	title of certifier	nd me	19	~	29c. License	number 9 T	V3	29d. C	Date signed (Mon	th, Day, Year)	
6+1		30. Name and addr	ress of person who	completed cause of d	ealth (Item 23a	a) (Type,	Print)	La	W STre	et	Aber	deer	
Sta Registr		31. Date filed (Mon	3 2 5 2008	32. Registra	ar's Signature	Gard	E)				1-16-4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 05532 Thomas Jonathan Harley, Jr. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 7, 2008 0415 hrs Medical Examiner Jonathan Harley Jr. Thomas 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country Months Days Hours Director Md. April 25,198 1 x M 2 20 Yrs 213-31-0612 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State any 10b. County 1 X Yes 2 No Fort Washington PG hours after death with the Maryland Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20744 3805 Pats Terrace **23**a Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces' 1 Never Married 2 Yes 2 X No 0 Specify:Black Yes 2 X No specify. Divorced If Yes, Give Year Widowed t. Pages 1 and 2 should be filed within 72 hours after truent of Health and Mental Hygiene retant: If item 27 is marked other than "natural", or other traumatic event, the Medical Framinary \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Warehouseman 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kim Dixon Be Thomas J. Harley Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3805 Pats Terrace Harley Sr. / father 20744 Thomas J. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 2/14/08 Clinton, Md. Resurrection Cem. Donation 5 Other Specify: 22. Name and Address of Facility injury 21 Signature of Funeral Service Licensee Hodges & Edwards F.H. Suitland, Md. 20746 Rd., Silver Hill art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and allure. List only one cause on each line. /Medica Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available peen 24a. Was an autopsy prior to completion of cause of certificate has performed' death? 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other₄ examiner' DOA Nursing Home 5 Residence 6 Inpatient 2 🗸 ER/Outpatient 3 After this 1 Yes 2 No 28a, Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Driver auto auto collision Feb 7, 2008 0030 hrs Natural Yes 2 V No within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Northbound Rte. 4 and Dowerhouse Road, Upper Marlbo determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD 32. Registrar's Signature

State

Registra

31. Date filed (Month, Day, Year)

5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1200 FEBRUARY 15, 2008 Elizabeth Hodges Hankins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 949 Braddock Road CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 □ F Months Hours MD 97 Mar 12, 1910 Director 214-05-4669 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ¥Yes 2 No Allegany MD Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 949 Braddock Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ 🔏 þ Specify: 3 XWidowed 4 ☐ Divorced white "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Mental H Be Karl P. Heintz Mora (Shepherd) Heintz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) is 1 and 2 soft Health an Item 27 is 3 Regatta Court Ridgeley WV 26753 Royce Hodges son permit. Pages 1 a Department of Hes Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State 2/16/2008 Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 234 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme fiate Cause (Final CEREBRAL VASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): ATHEROSCLEROTIC CEREBROVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-tran and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š CHRONIC ATRIAL FIBRILATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No SICK SINUS SYNDROME WITH PACEMAKER 24a. Was an

Physician Examiner

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

Division or Vital Records,

certificate has been page 2 rector, this (

Be

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Certification:

Medical

HYPOTHYROID

autopsy performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

1 ☐ Yes 2 N	0
27. Manner of Death	
1 Natural	5 ☐ Pending investigation
2 Accident	investigation
3 ☐ Suicide	6 Could not I

25. Was case referred to medical examiner?

on 6 ☐ Could not be determined

28b. Time of (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient

3□ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

31. Date filed (Month, Day, Year)

4 Homicide

🛮 🗶 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and title of certi Signatu and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

9 State

Registrar

To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After

the 1

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filled

JAMES M. RAVER M.D

600 MEMORIAL AVE., CUMBERLAND MD 21502

1 Inpatient

28a. Date of Injury



				Certificate of Death	1	Reg. No.	
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Physici /Medio		Anna Marie Kongelbeck		Februar		
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death		
			Brooke Grove Assisted Living Fac		Spring		gonery
ı	Funeral Director		1/1-09-4204 93	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da Oct 19	y, Year)). Birthplace (State or Foreign Country) ennsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	f she	ō	N	•			1 ☐ Yes 2 No
	28a	Director	MD Montgomery Sandy S 10e. Street and Number	pring 10f. Zip Code		10g. Citizen of Wha	at Country?
	3a or	ā	1635 Hickory Knoll Road	20860		JSA	,
	ms 2	Funeral		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto			American Indian,
_	or its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X ☐ YNo		Rican, etc.)		White, etc.
7	al', c	þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify:	White
2	should be filed within 72 hours after death with the Maryland not Mantle Hyglene. marked other than "natural" or items 23a or 28a-f show unstic event, the Medical Examiner must be incitied at	Completed	15. Decedent's Education 16a. Decedent of the complete of the	Decedent's Usual Occupation 'Give kind of work done during most of work	ina	16b. Kind of Busin	ness/Industry
7	ithin ne. ne.	du	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)			
7	led w lygier her th			emaker	(Fig. 4. 15: 1.11)	Own Home	
=	be find H	Be	17. Father's Name (First, Middle, Last)		e (First, Middle,	Maiden Surname)	
Š	d Mer d Mer narke	T ₀	Otto Nissler	Ann Dudt			
2	12 st h and 7 is n treur			Mailing Address (Street and Number or Rur 8 Iverleigh Court Po			
บ้	Healt Healt em 2			Disposition (Name of , crematory or other place)	Date	20c. Location - Cit	
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Throportant: If time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner man be notified at once.		I L Buriai 2 tx Cremation 3 L Hemoval from State				
altillio	it. Partme		4 □ Donation '5 □ Other (Specify) Che sape 21. Signature of Funeral Service Licenses /	eake Crematory 2 22. Name and Address of Facility	2/11/08	Beltsvil	le, MD
ם מ	permi Depar trapos any ir		5 1011 114	Going Home Crematio			
			23a. Part 1. Enter the disease, or complications that caused the death. Do no	Beverly L. Heckrott			
١.			shock, or heart failure. List only one cause on each line.	or enter the mode or dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	- 1			months
	Examiner		resulting in death)	cinoma of the col			TO CONTING
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	ate be nysici he bu	edical	Cause (Disease or injury that initiated events that initiated events resulting in death) Last Due to (or as a cor	nsequence of):			
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	e des the at hed fo	Physician	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23b. Did t	obacco use contri	bute to the cause of death?
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ָרָ בּי	signe	by					24b. Were autopsy findings
5	v require been sig should t	etec			24a. Was a perfor		available prior to completion of cause
2	has has be 2 s	Completed					of death?
					1 U Y	es 2 No	1 ☐ Yes 2 ☐ No
	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital:	26. Place of Death			cissisted
5	Phys rthis aral dii	- 1	1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outp. 27. Manger of Death 28a. Date of Injury 28b. Tin	atient 3 DOA 4 Nursing Ho		ence 6 COther (ow injury occurred	Specify) Living
5 :	Attending ir death. sctor: After by the fune	ţi	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation			, , ,	
	r dea	lfica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	n, street, factory, office			or Rural Route Number,
	al or safte	Certification:	4 ☐ Homicide determined building, efc. (Specify)		City or Tow	n, State)	
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.		29a. Certifier Certifying Physician: To the best of my knowledge, d	death occurred at the time, date and place,	and due to the d	ause(s) and mann	er as stated.
	the H	edlcal	(Check only one) 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occurr	ed at the time, o	date and place, and	I due to the cause(s)
	To t	Σ	29b. Signature and title of certifier	29c. License number	{	29d. Date signed (#	
			Mus attending physician	042046	8	epran	9,4008
0				ype, Print)	- 0		9,2008 20860
1			30. Name and address of person who completed cause of death (Item 23a) (Ty Chace Brooke Hoffman 18 IDO Stade SC 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 1 2008	hool Koad Sandy Sp	oring. 1	larylar	2 20860
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:10 PM 2008 February 6, Helen Lois Kulakowski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Earleville 3 Kent Road If Under 1 Year | If Under 24 | Months | Days | Hours | I Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 💢 F 217-30-9780 20, 1932 Director 75 Aug. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Earleville Ceci1 Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21919 USA 3 Kent Road Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 L.P.N. Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Unknown Richard Haslip 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 1238, Elkton, MD 21921 Ramona Raine/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 2-8-2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Foard Funeral Home, P.A. Rising Sun, Maryland R. T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21911 111 S. Queen Street, Rising Sun, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ongesti /Medical Due to (or as 1 onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tra The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months 4☐Pregnant at time of death 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part A Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 No 3 Probably 4 Bunknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∏ Yes 2 14 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA မ 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 1 Matural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Hornicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number arne and address of person who completed cause of death (Item 23a) (Type, Print) 123 TLAC LMI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 2008 Registrar

		•	For State Registrar	State of I	Marylan	d / Depa <i>Cer</i>	irtment of tificate of	Health and Death	l Mental Hyg	giene 2	08	05536
Ų.		,	Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath Day	Vane	Time of Death
	Physicia /Medic		Emma G	ertrude	Ku	bilu:	5		ÓA	09 2	3008 8	15 AM
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	Funeral			6. Sex 7. 1 ☐ M 2 X F	Age (in yrs.	last birthday) Yrs.	Months Day		in. (Month, Da	1931	Country)	(State or Foreign
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4	or 28;	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Country?	
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, de	tems left	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - American Ir k, White, etc.	ndian,
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7	giene	mo	9	College (1-4		School	l Bus Dr	iver		HOWALG	Court	<u> </u>
מום	al Hyg	Bec	17. Father's Name (First, Middle, L	.ast)					lame (First, Middle,	Maiden Sumam	10)	
2 4	Menta arked	2	Elmer Fred Corny	vell				Elsie M				
<u>a</u> 3	and is my is my		19a. Informant's Name/Relationsh						Rural Route Numbe			1e)
2 5	m 27		Darlene Mealey/I	Daugnter	20h E		LK Ridge sition (Name of	Lane, G	rantsvil	Le, MD 20c. Location -	21536	State
5	or of		20a. Method of Disposition 1 XBurial 2 Cremation			emetery, cren	natory or other p	/ace)				
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מ	Depar Impo		De Lyw	Demac					ntsville		536	
	hysician /Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aa.	h line.	ENOCCO	C.ncma	1	liac or respiratory ai	ver and	Inte	proximate erval Between set and Peath
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X 2	nding use a	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Dat	te of delivery	
The four contract that the doct contract the contract that the doct contract the co	requires the beath being been signed by the ettending p should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		n 2 ∏ Feta it at time of d n		JEctopic pregnar] Other (specify)			Мо	nth Day	/ Year
) i	d by the	Phy	9 Unknown Part II. Other significant condition	ne contributing to do at	th hut not roc	ulting in the u	doshing cause	awan in Part I	23e Did t	obacco use cont	ribute to the ca	ause of death?
CIUS,	signe d bed	1 by	Part II. Other Significant condition	is continuating to deal	ar but not res	alling in the di	idenying cause	giveri in it are i.		Yes 2□No	3 Probably	
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> 2	certi	o Be	examiner?	Hospital:	atient 2	ER/Outpatien	t 3 DOA)ther	Death (Check only only only only only only only only		er (Specify)	
5 8	er this	!-	27. Manner of Death	28a. Date of	Injury	28b. Time of				how injury occur		
	r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury	M 1	Yes 2 No				
SIVIS	ifter dei	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flace U	Injury - At h	ome, farm, str fy)	eet, factory, offic	ee ·	28t. Location (: City or Tox	Street and Numb vn, State)	er or Rural Ro	ute Number,
T Control	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 🖸 Certifying	Physician: To the be examiner: On the basi	est of my kno	owledge, death	n occurred at the	time, date and pla	ace, and due to the	cause(s) and ma	anner as stated	d.
1	the F	ledical	one)	and manner	r stated.					29d. Date signer		
É	To Too	Σ	29b. Signature and title of certifier	1			29c. Lice	nse number		250. Date signer	u (MOHIII, DAY	, , 541/
ı			Will To Will	1			V	4793	25	2/10/0:	9	
		1.	30. Name and address of person v	who completed cause	of death (Iter		Print)	1-1	~ 11	1 1.10	1/1	21100
	Sta	to	31. Date filed (Month, Day, Year)	32. Red	istrar's Signa	311 /U	WILL IT h	> MEGT	Caffe	W VV C	flad .	030
	Registr		FEB 1	3 2008	OF CAME	10° 1	grown)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** KOPIT ZAKHAR 17:50 02 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BENJERDA SUBURBAN 140161 JULY MONTGOMER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours **X**□ M 2□ F Months Days 88 Yrs Ukraíne 18, Director 220-41-0319 Dec. 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Funeral Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 10250 Westlake Drive, # 705 20817 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ž No Specify: q Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olga Mant Moisey Kopit ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Chestnut Hill Street, Gaithersburg. Md. 20878 Viktor Z. Kopit - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 2/10/2008 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Mary 20852 Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hours Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDUL INFARCTION /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to himmorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral.

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) Feb 6, 2008

1400 Forest Glen Rd #200, Silver Spring, MD 20910 Liebermon mn

29c. License number
20051817

State Registrar

Medical

31. Date filed (Month, Day, Year) 08 2008

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	waryian	•		nt of Fid te of E		a Mer	, ,	giene Reg. No.	0000	05538
	Physici	an	1. Decedent's Name (First, M	liddle, Las	t)							Date of Dea	Day	Year	3. Time of Death
(E)	/Medic				Kleinber			4h Cia	. Town or	Logation of Do		ebruary		2008	
	Examin	er	4a. Facility Name (If not instit	_		per)	4b. City, Town, or Location of Death Columbia			auı	4c. County of Death Howard				
快	Funeral		5. Social Security Number	6. Se	x 7	. Age (In yrs.	last birthday)	If Und	er 1 Year	If Under 24 H	Irs. 8.	Date of Birt (Month, Da	h v. Year)		rthplace (State or Foreign ountry)
	Director		112-24-4877		M 2□F	74	Yrs.	MOTATI	Days	Tiodio W		une 10,		3 1	New York
	land ow		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	Maryland	Howar	đ				Colu	mbia					1 □Yes 2 ☑ No
	vith the	Director	10e. Street and Number					10f. Z	ip Code				10g. Citi	zen of What C	
	eath v	Funeral	5845 Rin	g Dove	Lane 12. Was Deced	lent Ever in U	.S. 13.	Was Dec	edent of His	21044 spanic Origin? n, Mexican, Pu	? (Specify	/ Yes or No		U.S 14. Race - Am	S.A. erican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo		Armed Ford 1 Yes 2 If Yes, Give Year or Dat	ces? 2⊠No				n', Mexican', Pu Specify:	uèrto Ric	an, etc.)		Black, Whi	ite, etc. White
200	72 hou	ted	15. Dece (Specify only h	edent's Ed	ucation de completed)		16a. Dece	dent's Us	sual Occupa	tion uring most of i	workina	Į	16b. Ki	nd of Business	s/Industry
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d 2	e filed v al Hygie I other t vent, th		17. Father's Name (First, Mic	idle, Last)	5+			PI		18. Mother's N	Name (F	irst, Middle,			or hary rand
/lan	2 should be and Mental is marked or raumatic ever	To Be		Jack	Kleinberg						Est	elle Fe	eldmar	1	
Maryland	2 sho	ľ	19a. Informant's Name/Rela					-	,					r Town, State,	Zip Code)
	Health Health Jem 27	1	Susan Klein 20a. Method of Disposition	berg -	Wife	20b. F	Place of Dispo	sition (N	ame of	ine, Colu	umbia Date			21044 cation - City o	r Town, State
ē	Pages nent of nt: If ii		1 ☑ Burial 2 ☐ Cremat			tate	cemetery, crei lumbia N	-	-		/07/20	308	Co1u	ımbia, Ma	iryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Ser	vice Licen	Som	000	22 H	2. Name ines-	and Addres Rinaldi	s of Facility Funeral	1 Hom	e, Inc.	, ver St	nring. Ma	aryland 20904
	æ		23a. Part1. Enter the disease shock, or heart failure.	e, or comp	lications that ca	used the deat								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between
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	/Medical Examiner		resulting in death)		Due to (o	r as a conseq	uence of):			,					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. Dus to (o	л аз а сспану	uence of j.								
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0	the dea	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregna 9⊡Unknov	ant at time of o	death 5	Other ((specify)		<u></u>				,
ر. ت	requires that the een signed by th	by Ph	Part II. Other significant co	nditions o	ontributing to dea	ath but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco u	ise contribute	to the cause of death?
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or Vital Records	8 8	Completed									_	24a. Was		24b. Were a prior to death?	autopsy findings available completion of cause of
a	n: The lificate harry, page		25. Was case referred to me	rdical [00 Di	Darah (6	1□ Yes	2 No		s 2 No
Ž	Physician: this certific ral director,	To Be	examiner?	1	Hospital: 1 ☐ In	patient 2	ER/Outpatie	nt 3 🗆 I	DOA Othe	26. Place of I				6 ∐Other (Sp	ecify)
0 U	ng Ph fter th neral		27. Manner of Death 1 Manual 5 □ Pe	endina	28a. Date or (Month	f Injury n, Day Year)	28b. Time o Injury	of	28c. Injury Work	at ?		I. Describe			
Division	tend death. ctor: / the f.	icati	2 Accident in 3 Suicide 6 Co	vestigation ould not be	28e Place	of injury - At h	ome farm str	M reet fact		′es 2 No	28f	Location (Street an	id Number or F	Rural Route Number,
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	he Hosp n 24 hou he Fune pletely fi	Medical			ysician: To the la niner: On the ba and mann	sis of examina									as stated. ue to the cause(s)
	To the Position 24	Ž	29b. Signature and title of ce	ertifier U	w)			2	9c. License	number 8303	3		29d. Dat	te signed (Mor	nth, Day, Year)
	10		30. Name and address of pe	rson who	completed cause			Print)	00-	/ . · · · ·	- 0	1.21	· / //	0 2 121	152008
			MARON S		WES V		5701 C	D.	irar	ع الم	10	W20/	0,700	, 42	7
	Sta		31. Date filed (Month, Day,	8 20	N8 32 Ne	egistrar's Sign	A A	and C							

DHMH 17 Rev 1/2001

08-01356 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gerald Edward Karl 2008 05539 1- For State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 16, 2008 **Medical Examiner** Gerald E. Karl 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Freeland I-83 south of Downes Road Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min. Director 100-32-7601 $_{1}X_{M}$ 66 April 29, 1941 Country) Yrs Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 10a, State 10b. Count or items 23a or 28a-f show must be notified at once. PA York Wellsville imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho irector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 538 South Kralltown Rd. 17365 U.S.A. ö 14. Race - American Indian. Black. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes White Specify: If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Divorced event, the Medical Examiner \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator 11 Aviation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emil A. Karl, Jr. Ruth Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Karl/Wife 538 South Kralltown Rd., Wellsville, PA 17365 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore, permit. Pages 1 and 20a. Method of Disposition Burial 2 X Cremation 3 X Removal from State Cremation Direct Service
Donation 5 Other Specify: / Of York County Crematory Feb. 22, Department o Important: injury or oth York, PA 17401 2008 4 Donation 5 Other Specify: 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signatur of Funeral Service License 24 Second St., New Freedom, PA 17349 Rin Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit cal ned by the attending physician a detached for use as the burial -UNPENDED AMENDED ician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Month certificate has been signed by the attending ector, page 2 should be detached for use as t Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical funeral director. Be Other₄ examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this

of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Director:

pital or Attending Physician:

	To the Hos	within 24 h	To the Fun
•	9	0	

Margarita Korell MD. 31. Date filed (Month, Day, Year) State Registra

29b. Signature and title of certifier

Molline

1 V Yes

Certification:

cal (Che one)

2 🗸

filled in by the

completely

27. Manner of Death

Natural

Accident

Suicide

Homicide 29a. Certifier

2 No

Pending

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner Registrar's Signature

28a. Date of Injury (Month, Day, Year) FOUND:

(Specify) Interstate/Express

Feb 16, 2008

and manner stated

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 ✔ No

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

FOUND:

1100 hrs

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Driver auto fixed object collision

or Town, State) I-83 south of Downes Rd, Freeland, MD

28f. Location (Street and Number or Rural Route Number, City

February 17, 2008

1100 hrs

NY

Yes 2 X No

Approximate Interval

Between Onset and

Death

2 No

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

ō

'natural",

than

f Health and Mental Hygiene. Item 27 is marked other than

permit. Pages 1 Department of H Important: If Ite

injury

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

þ

Completed

Be ဥ

physician within 24 hours area To the Funeral Director: Aft

Examine by Physician/Medical Completed Be 7 Certification: 29a. Certifier Medical

2 Accident 3 ☐ Suicide 4 ☐ Homicide

IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

5 Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

CHOSTONTOUN

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 SCHOKS ST

PAYL JOINSON MOFINS 31. Date filed (Month, Day, Year)

FEB 2 5



State

Registrar

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Р Jan 20,2008 Jennifer A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Year) Feb 2,1970 If Under 1 Year | If Under 24 Hrs. 6 Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 ₩ F 37 California 263 71 0819 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1. Yes 2 No Director VAVirginia Beach 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23455 586 DeLaura Lane US Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2**X**Xo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Mortgage Broker</u> Bank permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any Injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Low Norvella Penny Kemp ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) George Low - Father DeLaura Lane, Va Beach, Va 23455 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kempsville Crematory 1/27/08 Va Beach, VA 21. Signature of Funeral Service Lice 22 Name and Address of Facility Kellum Funeral Home 601 N Witchduck Rd, Va Beach, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) an/mon. **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and Due to (or as a conseque physician Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Daÿ 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □ nknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∐°No 3□ DOA Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospita! I ⊈Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar 30. Name and address of pe

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31. Date filed (Month, Day, Year)

FEB 08

DHMH 17 Rev 1/2001

Much

son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

08-01382 John Michael Lyons

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05542

	i wildrider Ly		1- For State Certificate Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
Mer	Physicia dical Exami		John Michael Lyons			Year 1005 hrs
als.	arear Exami		4a. Facility Name (if not institution, give street and number) 6413 Davis Road	4b. City, Town, or Location of Death		nty of Death
	Emanal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			YYY) 9. Birthplace (State or
	Funeral Director		220-80-3028 1X M 2 F 45	Yrs. Months Days Hours Min		Foreign
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	\$	_	MD Carroll Mt. Airy			1 Yes 2 X No
_	te Maryland or 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. Citizen o	f What Country?
0	the M a or 2		6413 Davis Road	21771	USA	
=	r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Race - American Indian, Black, Vhite, etc.
	after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X No specify:		_{ify:} White
	hours: natur	Pg Pg	durin	edent's Usual Occupation (Give kind of ig most of working life. DO NOT use re		of Business/Industry
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		ostripper	Print	
	15-C	- a. I	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surn	
	MD 21215-0036 nd 2 should be filed within 7 atth and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	To Be	John Michael Lyons, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Virginialing Address (Street and Number or	a Emilv Feller Rural Route Number, City or	Town, State, Zip Code)
	MD d 2 sh lth and n 27 is numat			3 Davis Rd. Mt. A	iry, MD 21771 Date 120c. Locat	tion - City or Town, State
	S 1 an of Hea		1 Buriel 2 X Cremation 3 Removed from State crematory of	sposition (Name of cemetery, or other place)		
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify:			sville, MD
	Ball permit Depar Impor		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Going Home Cremat: Royorly I Hockro	ion Service E	2.0. Box 784
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest, shock, o	Approximate Interval Between Onset and
120	/Medical Fxaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (morphine) in Due to (or as a consequence of):	toxication		Death
		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		nine	cause. Enter Underlying Cause (Dispess or injury that initiated C.			
	cuted ind transit	al Examiner	events resulting in death) Last Due to (or as a consequence of): d.			
	Box 68760, death certificate be executed ne attending physician and of for use as the burial - transit	Medical	□ MENDED □ AMENDED	g876, 2/28/08 TT	224 Da	ate of delivery
	876 tificate ng phy as the l		IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg		·
	Box 687 e death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
	G 5 G 10	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
	Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certifin rs after death. "In Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as t	þ			1 Yes 2 No	o 3 Probably 4 🗹 Unknown
	rds, requir been s hould	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	eco he law ate has	duc			performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
	al R an: T ertifica ctor, p	BeC	25. Was case referred to medical	26.Place of Death (Chec		
	of Vital I fing Physician: After this certifi funeral director,	ToE	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			6 ✔ Other: Scene
	n of		27. Manner of Death 1 Natural 5 Pending T-d 2/17/2009 T-d 6	e of Injury 28c. Injury at Work?	28d. Describe how injury o	occured
	Sion Attend r death. ector: by the f	cati	2 Accident Pending Investigation Prod 2/17/2008 Fnd 9	7:43 am A	unk 28f. Location (Street and N	Number or Rural Route Number, City
	Divi	Certification:	Suicide 6 X Could not be determined (specify) found at home	,,	6413 Davis Road	l Mt. Airy, MD
	Division of Vital Records, P.O. I To the Hospital or detailing Physician: The law requires that the within 24 hours after detail. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	Certifying Physician: To the best of my knowledge, death of one) Certifying Physician: To the best of my knowledge, death of one) Wedical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause(s) and made at the time, date and place,	anner as stated. and due to the cause(s)
	To To 1	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)
			Det a Real	O.C.M.E.	Februa	ry 18, 2008
1	7		30. Name and address of person who completed cause of death (Item 23a)			
	Ors		Patricia Aronica-Pollak MD. Assistant Medical Examine	er 111 Penn Street, Baltim	ore, MD 21201	
	S Regis	tate	FFB 7 11 /11101 /10/20.42 . /6	boarde		

08-01042 Scott David Lawson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Hoolth and Martinian

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tate (of Ma	arvland /	Department	of Hea	ith and N	∕lental l	Hygiene

	_	1- For State Registrar	Cel	rtificate					eg. No.	UUO	UDDH
Physicia ledical Exami		1. Decedent's Name (First, Middle,La Scott David Laws)	•					2. Date of Dea Month February		. 1	ne of Death 300 hrs
u .		4a. Facility Name (if not institution, gi			4b. City,	Town, or	Location of Deat		4c. County o		
		Chambers River Road an				nsville			Anne Aru		
Funeral Director			, ,		/rs. If Und	ler 1 Yea			/1965	9. Birthplace Foreign Country)	`_
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation					10d. I	Inside City Limits
	'n	MD Anne Arı	ınde1 Cı	ownsv	ille					1 [Yes 2 X No
Maryla 28a-f dato	Director	10e. Street and Number			10f. Zij	p Code			l 0g. Citizen of Wh	at Country?	
ith the 23a or notifi		1120 Valentine (<u> </u>			21032		US		fire Direk
eath with the Maryland items 23a or 28a-f show ust be notified a conce.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?				spanic Origin? (\$ n, Mexican, Puert		White	- American Ind , etc.	dian, Biack,
P 5 E	by Fu		1 Yes 2X No	1	Yes 2	No	specify:		Specify:	White	
hours 'natur Exami	ed k	15. Decedent's Education (Specify of					tion (Give kind of . DO NOT use re		16b. Kind of Bus	siness/Industr	у
215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. The dother than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be natified a Lonce	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sa	alesma	an			F1	ooring	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Con	17. Father's Name (First, Middle, Las	·			T			Maiden Surname)		
121 Id be fi Jental narked event,	o Be	William Lee Laws 19a. Informant's Name/Relationship (THE PROPERTY OF THE PARTY OF TH	I 10h Mail	lina Addros	s /Strac		Sievers	mber, City or Town	State Zin C	'obo'
MD 2 d 2 shou Ith and M n 27 is n	^L	William Lee Laws							, MD 210.		ode)
re, N 1 and Thealth fitem er trau		20a. Method of Disposition		Place of Disp crematory or			metery,	Date	20c. Location -	City or Town,	State
Pages Pages nent of		1 XX Burial 2 Cremation 3 4 Donation 5 Other Specify	F.r	iphany	7 Ceme	etery		10/2008	Odento	-	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Lice	nsee	22	Name and	d Address lgely	s of FacilityHar y Ave.	desty F Annapol	uneral Ho is, MD 2	ome, P. 1401	.A.
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e		. Do not ente	r the mode	of dying,	such as cardiac	or respiratory ar	rest, shock, or hea		proximate Interval tween Onset and
kaminer		Immediate Cause (Final disease a or condition resulting in death)	Multiple Injuries Due to (or as a consequence of	of).							Death
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sd ssit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):							
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Box 68 death certif the attending of for use as	iciar	past 12 months?	1 Live birth 4 Pregnant at time of de		Fetal death Other (Sp		Ectopic pregi	nancy	Month	Day	Year
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P.O.	by	Part II. Other significant conditions	contributing to death but not t	esuiting in th	e underiyin	ig cause (given in Part I.		es 2 No 3		
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of Vital Records, ag Physician: The law require the continuate has been sineral director, page 2 should t	ldmo								ormed?	rior to comple leath? Ves	etion of cause of
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on of nding F th. r: After re funer		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of FOUND:	of Injury		ry at Work? Yes 2 ✔ No		how injury occurruto to fixed ob		on
Division tal or Attendin rs after death. al Director: A led in by the fu	Certification:	2 ✓ Accident Investiga 3 Suicide 6 Could no	280 Place of Injury - At h	2254 hrs iome, farm, st	treet, factor	y, office b	ouilding, etc.		(Street and Number	er or Rural Ro	oute Number, City
Div	Certi	4 Homicide determine		et				or Town, Chambers R	State) iver Road and C	Old Harold H	larbo, , MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	29a. Certifier Check only 1 Certifying Physic Check only 2 Medical Examine	ian: To the best of my knowled r:On the basis of examination a	ige, death oc and/or investi	curred at th gation, in m	e time, da ny opinior	ate and place, ar n, death occurred	nd due to the cau dat the time, date	ise(s) and manner e and place, and d	as stated. ue to the caus	se(s)
To with To Com	Mec	29b. Signature and title of certifier	and manner stated.				se number		29d. Date sign		
		Parte Pourthon	(m)			O.C.	M.E.		February 6	, 2008	
111 0			completed cause of death (Item		111 D	n Ctr	t Daltimass	MD 24204			
S AR	ate	Pamela E. Southall, MD 31. Date filed (Month, Day, Year)	Assistant Medical Exa		Peni	oree	t, Baltimore,	IVID 2 1201			
Regist		^ ^ ^	2008 Elecus	J.	book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Р Richard E. McVay, Jr. Eeb. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges <u>Southern Maryland Hospital</u> Clinton nder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X** M 2□F Director 219-40-1881 63 Ju<u>ne</u> 29, 1944 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Me. K.al Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince Georges Brandywine 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20613 USA 5011 Floral Park Road Funeral Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after I∏Yes 2**X** No fYes, Give 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 🎾 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Master Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi Richard E. McVay, Sr. Marjorie Cooper Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum Linda L. McVay/ Wife <u>5011 Floral Park Road, Brandywine, Maryland, 20613</u> Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Feb. 6, 2008Waldorf, Maryland Huntt Crematory 21. Signature of Funeral Service Licensee 401862 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, Maryland, 20601 or complications that caused the death. Do not enter the mode List only one cause on each line. 23a. Part1. Enter the diseas f dving, such as cardiac or re Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) buria!physician the burial Box 68760 Physician/Medical as IF FEMALE for use If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 2 V No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe Division or Vital 1∐ Yes 2XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient ဥ 2 ☐ ER/Outpatient 3□ DOA After this Date of Injury Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After 5 Pending investigation (Month, Day Year) Injury 1 Natura! 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

31. Date filed (Month, Day, State Registrar

FEB 08 2008

Year)

Kein

29b. Signature and title of certifier

30. Name and address of



erson who completed cause of death (Item 23a) (Type, Print)

Centre Suite 207 Waldon Fud 20602

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05546 State of Maryland / Department of Health and Mental Hygiene U 0 8 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February 12, 2008 12:16 AM **Physician** Robert Charles Myslak /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett 4635 Cranesville Road Oakland If Under 1 Year | If Under 24 Hrs. 8.
Months | Days | Hours | Min. Birthplace (State or Foreign County) aryland Date of Birth (Month, Day, Year) February 23, 1960 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 M 2 □ F 218-76-7619 47 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 le marked other than "naturel", or items 23a or 28a-f ehow empiriquy or other traumatic event, the Medical Examination of content and the page. 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No Fallston Hartford Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21047 2419 Baldwin Mill Road Apartment 1 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Automotive Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Marie Mohr Walter Myslak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 349 Terra Alta Lake Road, Terra Alta, West Virginia, 26764 Susan Eichhorn - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland, Maryland **Cumberland Crematory** 4 □ Donation 5 □ Other (Specify) 22. Name and Address Plendorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 2. 8 East Main Street, Lonaconing, Maryland, 21539 23a. Parl 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years cirrhosis **Physician** /Medical Examiner lcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sete hes been signed by the attending physicien page 2 should be detached for use as the burial Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Da Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Minknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificete hes 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of D-ath Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

Medicai

29b. Signature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2008

garret

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10, 2008 Physician John M. Mellendick Sr. 2:00 a M February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9305 Knoll Stone Ct. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year, 3/16/1932 Months XXM 2□F Hours Min. 219-28-1002 75 Maryland Director Usual Residence of Deceden with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits works 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Md. Directo Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9305 Knoll Stone Ct. 21.042 USA death Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene.

77 is marked other than "natural", or ite 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appraiser State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Mellendick Veronica B. McCurnin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trains Joan C. Mellendick/wife 9305 Knoll Stone Ct. Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/11/2008 Hanover, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service License 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final Physician COHOLIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 MrUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy perform **2**ONo 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Alatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 281

DHMH 17 Rev 1/2001

State

Registrar

1 ASNEEM

31. Date filed (Month, Day, Year)

FEB 1

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

411 Lags

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AVE, SUITE 213, BACTO MA 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

f Maryland / Department of Health and Mental Hygien 2008	0	55	5 [-

		1 - For State Registrer	ate of Maryland / D	Depar <i>Certi</i>	tment of H	lealth and M Death		en e 008	05548
		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physici		Etta May Miller					Month Februar	y 7, 2008	6:10 A ^M
/Medic		4a. Fecility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of Death		4c. County of Death	0.10 11
		60 Cross Keys Road				North Eas	t	Cecil	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		tf Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
irector		159-28-1928 ^{¹□ M}	² X F 76	Yrs.	Months Days	Hours Min.	Jan. 17	1932 Vi	rginia
		Usuet Residence of Decedent							
ahow Territory	_	10a. State 10b. County	10c. City, Towr	n or Loca	ition			1	10d. Inside City Limits
Sa-f	cto	Maryland Cecil	Nor	th E	ast				1 Tes 2 No
or 2	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
123a	ra a	60 Cross Keys Road				901		USA	
tema ar m	Funeral		Vas Decedent Ever in U.S.	13. Wa	as Decedent of H res, specify Cuba	ispanic Origin? (Spanic Origin)	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
o di	by Fi		☐ Yes 2 🕅 No Yes, Give		Yes 2⊠No			Specify:	
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"nat	Completed	15. Decedent's Education (Specify only highest grade con		(Give kii	nt's Usuat Occup nd of work done of NOT use retired	during most of work	ing 1	6b. Kind of Business/In	dustry
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ther int.	ပိ	17. Father's Name (First, Middle, Last)		поп	nemaker	18 Mother's Name	e (First, Middle, M	Own Home	9
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nark	ှင	19a. Informant's Name/Relationship (Type, F	Print) 10h	Mailing	Address (Ctrast	Leona		City or Town, State, Zip	Code
7 ts trau				_					
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# io		1 X Burial 2 ☐ Cremation 3 ☐ Remo	val from State cemeter	y, crema	tory or other plac	:e)	1/2		
Department of result and weather registers, or learne 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		* 4 □ Donation 5 □ Other (Specify)	Calver	***		em. 2-11-	-2008 R	lising Sun,	Maryland
any i		21. Signature of Funeral Service Licensee	1.		Vame and Addres	d Funeral	Home P	.A.	
7.2 6 G		Kichard A.	Sorgie	1111	S. Que	en Street	, Rising	Sun, MD 21	
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page	5						performe	ed? death? 1 ☐ Yes	2 No
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led ii									
To the Funeral Director; After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edicai	(Check only 2 Medical Examiner: (n: To the best of my knowledge. On the basis of examination and and manner stated.	, death o d/or inves	ccurred at the tim stigation, in my of	ne, date and place, pinion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as si e and place, and due to	tated. the cause(s)
To th	Me	29b. Signature and title of certifier	•		29c. License	number	290	d. Date signed (Month,	Day, Year)
		· Roya · T	del An		1+	006285	-,	2/8/08	
		30. Name and address of person who comple	ted cause of death (Item 23a) (Type Pri	int)	~~(ya. ~3	1	2(4100	
		Bonni Robert	3 361 F	ain	the E	J. EIKH	m MD	21921	

State

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at each

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

RT

Bonni Roberts
31. Date filed (Month, Day, Year) FEB 11





Registrar

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	1	For State Registrar	Oldio	- Waryiai		rtificate of			Reg. No	6000	00049		
sicia		Decedent's Name (First, Middle DORTC		36	TT T D'D			2. Date of D Month 02	Day		3. Time of Death		
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min	EI	WMHS - MEMORI				CUMBE	RLAND			ALLEGA			
ral tor		5. Social Security Number 215-20-7226	6. Sex 1 ☐ M 2%D ÆF	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		19 Year)	9. Birtl P25 Mar	hplace (State or Foreign untry) cyland		
		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits		
	ector	MD. Alle	gany		Barto					izen of What Co	1 □Yes 🏖 No		
	Funeral Director	10e. Street and Number 19423 Dogwood	19423 Dogwood Flat Lane					21521 United					
	þ	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	Armed F	2 X No ive		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				Specify:	e, etc. nite		
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	omp	Elementary/Secondary (0-12) unknown	College (1-4or 5+)		omemaker	<i>3)</i>		Ho	ousework			
	To Be Completed	17. Father's Name (<i>First, Middle,</i> Paul Walbe					18. Mother's Na Mil	*	e, Maiden ank	Surname)			
		19a. Informant's Name/Relations Edward Paul Mi		band		ng Address (Street 3 Dogwood							
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, cre	osition (Name of matory or other place ill Cemet		Date 707/ 08		ocation - City or ton, Mar	•		
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	by Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes 2□ No 9□ Unknown 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□ Pregnant at time of death 9□ Unknown 23d. D N 1□ Live birth 2□ Fetal death 5□ Other (specify)									livery Day Year		
	y Ph	Part II. Other significant conditi	ons contributing to	leath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
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	ertifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	.: Zoe. Plac	e of injury - At I ling, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location City or To	(Street alown, Stat	nd Number or Ru e)	ural Route Number,		
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	10	30. Name and address of person	who completed cau			Print) Ave. Co	MPCDI	ALID !	MD :	21502			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Ma	yland / Department of Health and Mental Hygiene	(U

Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Felavary 6, 2008 **Physician** 0315 MYRTLE MILLER EUZABETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sandy Spring

If Under 1 Year | If Under 24 Hrs.

Hours | Min. Montgonery Brooke Grove Remosilitation and Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🛛 F Yrs. Director 579-22-8089 March 14, 1915 Washington, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ∑Yes 2 ☐ No Virginia Fairfax Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3507 Wilson Street 22030 Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Veterans Administration Clerical 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event 9DRS. Be Ε. Kirby Bernard Cooper Bettie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3507 Wilson Street, Fairfax, Virginia 22030 Bettie Searfoss/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 02/11/2008 Fairfax, Virginia Fairfax City Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly Funeral Home 10565 Main Street, Fairfax, Virginia 22030 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAYS Physician FNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ADVANCED SENILE DEMENTA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy has 1 Yes 2 No certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of after death. I Director; After the or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours af To the Funerel Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu e and title of certifier - ATTENDING PHYSICIAN D42046 February 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooke Hiffman, M.D. 18100 Stade School Road Sandy Spring, Maryland 20860 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 2008 FEB Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene?

			1 - For State Registrar	State of Ma			ate of D			eneZ U U B	00001	
	Physici	an	1. Decedent's Name (First, Middle, Las	r)					2. Date of Death Month	Day Year	3. Time of Death	
	/Media	al	John P. Martin						February	6, 2008	7:00a M	
	Examir	er	4a. Facility Name (If not institution, give Holy Cross Hospi	•			lver Sp	ocation of Death Oring	4c. County of Death Montgomery			
1	Funeral Director		5. Social Security Number 6. Se 217-44-5931		(In yrs. last birtho	Mont	Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Jan. 23, 1945 Washington, DC					
	land DW		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits	
	Mary a-f ah	tor	Maryland M	ontgomery		Silve	er Spri	nα		1 ☐ Yes 2 🗷		
	or 28:	Director	10e. Street and Number				Zip Code		10	g. Citizen of What Cou	ntry?	
	s 23a	rai	10121 Markham S				209			USA		
920	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mudicul Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? ★★★Yes 2 ☐ N If Yes, Give Year or Dates:	Vietnam		scedent of Hisp specify Cuban, s 25xNo		pecify Yes or No- o Rican, etc.)	14. Race · Ameri Black, White, Specify: Whi	etc.	
5	72 ho natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. De	ecedent's U	Jsual Occupati work done du	on ring most of wor	king 1	6b. Kind of Business/Ir	dustry	
7	within ene. then '	mpi	Elementary/Secondary (0-12)	College (1-4or 5	lif	e. DO NO	Tuse retired) Teac			Education		
2	Hygid other ont, I	Be Co	17. Father's Name (First, Middle, Last)		4				ne (First, Middle, M			
lar	should be nd Mental marked o	To B	Charles David Ma	rtin				Cathe	rine Gene	evieve McGr	ath	
, Maryland 21215-0036	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (7) Marsha L. Taylor/	•						City or Town, State, Zip Spring, M		
Baltimore,	Pages 1 nent of He ent: If Iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		20b. Place of Di cemetery, of MD Vete	crematory (or other place)	reb.	19,	Oc. Location · City or To Cheltenham,		
Balt	permit. Page Department of Importent: If any Injury or		21. Signature of Buneral Service Lights Kuchand	60					Funeral	Home Inc.	ng, MD 2090	
Ε	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Soundly list on the fit of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	al Diseas	7	Approximate Interval Between Onset and Death days Months						
Box 68/60,	death certificate be executed e attending physicien and of for use as the burial-transit	an/Medical	IF FEMALE: 23b. Was decedent pregnant	23d. Date of delive								
л. О.	0 0 0	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								Month Day Year	
•	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions co Prostate Cancer,				ig cause given	in Part I.		accoluse contribute to t		
Vital Records	The law ate has b page 2 sl	Completed	Recent Myocardial Chronic Obstructi			ary A	Artery	Disease	24a. Was an autopsy perform	ed? prior to co	ppsy findings available mpletion of cause of 2 No	
VII	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	donnital:	10.10.10.10.10.10.10.10.10.10.10.10.10.1		1 0		th Check only one			
5	Phy rald	2	1 Yes 2 No 27. Manner of Death		nt 2 ER/Outpa			4 🗀 Nursing 🗅	ome 5 Resider	ce 6 Other (Special	(y)	
<u></u>	Attanding F r death. ector: After by the funera	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Injus		28c. Injury a Work? 1 ☐ Ye	s 2 No	200. 00001100 1107	injury becamed		
DIVISION	₹ ne o ya	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home, farm, . (Specify)	street, fac				eet and Number or Rura State)	al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exemi	sician: To the best of ner: On the basis of and manner sta	examination and/or	eath occurr r investigat	ed at the time, ion, in my opin	, date and place, nion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as s e and place, and due to	tated, o the cause(s)	
	To the complet	Σ	29b. Signature and title of Certifier	entin	Jan		29c. License r D53	number 367	29	d. Date signed (Month, February		
	•		30. Name and address of person to co Rajan Shyamsundar	, MD 98	01 Georgi		enue, #	117, Si	lver Spri	.ng, MD 209	02	
4	Sta Registra	_	31. Date filed (Month, Day, Year) FEB 0 8 20		r's Signature	hort						

2/8 (23 # # B - OK per chartille /4/10

08-01328 Albert C. Mattern Plea

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State of Maryland / Department of Health and Mental Hygiene
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ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	2008	05552
Certificate of Death	2000	00002

		I- For State	or waryland		cate of De			,55	Reg. No.	201	18 0000
Physicia	_	Registrar 1. Decedent's Name (First, Middle,La	st)					2. Date of D	eath	Year	3. Time of Death
Medical Exami				Matterr					y 15, 2008		2212 hrs
		4a. Facility Name (if not institution, g				ity, Town, or alisbury	Location of	Death	Wicor	nty of Death	
		Peninsula Regional Medi 5. Social Security Number 6.5		e (In yrs. last b		Under 1 Yea	r If Under	24Hrs. 8. Date of	Birth(MM/DD/Y)		hplace (State or
Funeral Director		205 00 1005		16	М	onths Days		Min	1/1961	Foreign	
		Usual Residence of Decedent	(M 2 F		Yrs.			07/0	±/ 1301		rat y ture
any	ŀ	10a. State 10b. County		10c. City, Tov	n or Location						10d. Inside City Limits
ihow id	ايا	Maryland Wicom	ico]	Pittsvil	lle					1 X Yes 2 No
Sa-f saton	Director	10e. Street and Number			10f	. Zip Code			10g. Citizen of		itry?
$\int_{\mathbb{R}} \int_{\mathbb{R}} \int$	ä	8069 Gumboro Ro				21850			USA		
ICU32 redeath with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	12. Was Decedent		13. Was De	cedent of His	panic Origin Mexican, I	n? (Specify Yes or Puerto Rican, etc.)		ace - Americ /hite, etc.	can Indian, Black,
r deatl or ite	핊	1 Never Married 2 Marrie	1 X Yes 2	No					Spec	the s	
s afte	2	3 Widowed 4 X Divorce 15. Decedent's Education (Specify		cmv		2 X No		ind of work done	Spec.	f Business/Ir	
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or		during most o	f working life	. DO NOT u	ise retired)			
336 thin 7 re. than	휠	12	2+	,	worker				HVA	.C	
215-0036 be filed within 7 stal Hygiene. Red other than ent, the Medica		17. Father's Name (First, Middle, Las	t)					Name (First, Midd		ame)	
121 1 be fi ental l arked vent,	Be	Albert Mattern						Helmstett Der or Rural Route		Town State	Zin Cade)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a. Informant's Name/Relationship Sue Brandick/mc			8069 (Gumbor	o Rd.	, Pittsvi	.lle, MD	21850))
e, h I and I Health item	-	20a. Method of Disposition		20b. Plac	e of Disposition	(Name of ce	metery,	Date	20c. Locat	ion - City or	Town, State
nor Pages ent of nt: If		1 XBurial 2 Cremation 3 4 Donation 5 Other Specia	Removal from St		rn Shor rans Ce			2/20/08	Hurl	ock, N	MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Lice	ensee	<u> Ivete</u>	22. Name	and Addres	s of Facility	cal Home	Profess	ional	Association
E E E E		Herle K Xtour	ac CESS	-	501	Snow	Hill	Rd., Sal	isbury,	MD 21	.804
Physician		23a. Part I. Enter the dise se, or corfailure. List only one cause on	nplications that caused each line.	the death. Do	not enter the m	ode of dying	, such as ca	erdiac or respiratory	arrest, shock, o	r neart	Approximate Interval Between Onset and Death
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Sepsis								Death
			Due to (or as a cons	equence of):							
	je.	if any, leading to immediate	Due to (or as a cons	equence of):							
	Examiner	cause. Enter Underlying Cause (Disease or Injury that imitiated	Due to (or as a cons	equence of):							
uted id ansit		events resulting in death) Last	d.								
760, icate be executed physician and the burial - transit	ledical	X UNPENDED	AMENDED 23	,27 per	ME g878 4	1/3/08 a	mh				
760, cate b physic	≥	IF FEMALE:	23c. If yes, outco	me of pregnan	су					te of delivery	
rds, P.O. Box 687 requires that the death certific been signed by the attending I hould be detached for use as it	hysician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	t time of death	2 Fetal d	eath 3 (Specify)	Ectopic	pregnancy	Mon	tn L	Day Year
30x death ne atte 1 for u	ysic	1 Yes 2 No 9 Unkno	wn 9 Unknown		5 Other	(Speciny)			100		
O. E at the 1 by the	۵	Part II. Other significant condition	s contributing to dea	th but not resu	Iting in the unde	rlying cause	given in Par	_			the cause of death?
, P.O.	d by			 					Yes 2 No		bably 4 Unknown
Vital Records ysician: The law requii his certificate has been i director, page 2 should	Completed								utopsy	prior to o	utopsy findings available completion of cause of
ecc he lav ate has	m o								erformed? es 2 No	death? 1 ✔ Ye	es 2 No
al R an: T ertific tor, p	0	25. Was case referred to medical				26.Plac	,	(Check only one)			
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati		2/Outpatient 3	DOA	Other ₄	Nursing Home 5			er:
of Of Ving Phys. After the funeral		27. Manner of Death 1 X Natural 5 Pending	.28a. Date of Inj (Month, Day,		b. Time of Injury		ury at Work' Yes 2		ibe how injury o	scurred	
ivision or Attem after death Director:	catio	2 Accident 5 Pending Investig	ation	nium. At home	e, farm, street, fa				on (Street and N	lumber or R	ural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirm and after death. In Director: After this certificate has been silled in by the funeral director, page 2 should t	ertification:	3 Suicide 6 Could n	ot be	njury - At nome	s, iaiii, sireei, ia	actory, office	bullarily, ca		vn, State)		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	ပ	29a. Certifier 1 Certifying Phys	ician: To the best of r	nv knowledae.	death occurred	at the time, o	iate and pla	ice, and due to the	cause(s) and ma	nner as staf	ted.
thin 24 the F the F mplete	Medical	one) 2 ✓ Medical Examin	er:On the basis of example and manner stated	amination and/	or investigation,	in my opinio	n, death oc	curred at the time,	date and place,	and due to th	he cause(s)
To To	Me	29b. Signature and title of certifier	and manner stated	·		29c. Licen	se number		29d. Date	signed (Mo	onth, Day, Year)
		desha	Tesh	LD		0.0	.M.E.		Februa	ry 16, 200	08
		30. Name and address of person wh									# P
		Tasha Greenberg MD.	Assistant Medic				, Baltimo	re, MD 21201			
S Regis	tate	31. Date filed (Month By, X2ar)	2008 32. Sqistr	ar's Signatur	GOOM	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Month 2/7/2008 **Physician** Doris Lucille Mossburg 0235 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Month, Day, Year) 11/06/1921 Months 1 □ M 2 🕏 F Maryland 577-20-5142 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bayfront Dr. Apt. 414 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€3 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygiel ' is marked other th Officer [] Banking permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Hardesty Daisy Burgess ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Frank Moreland Place Lothian, MD 20711 Marjorie Moreland 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2/11/2008 Brentwood, MD 21. Signal re of Fundral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death riate Couse (rinal se or condition ting in eath) CARDIAC **Physician** /Medical Due to (or as a consequence of): DAYS YOCARDIAL **Examiner** Sequentiall, It conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine VALVE HORTIC death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

FEB 0 8 2008

32 Registrar's Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a) Type Print) EST GATE ROAD, STE 211, ANNAPOLIS MAD LOUIS & ESS ANDOH, MD 8888 BEST GATE ROAD, STE 211, ANNAPOLIS MAD

02 - 07 - 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2008 4:00 AM February Enid E. Madel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Life Assisted Living Charles County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 □ XF Months Days Hours 1919 Director Nov. Connecticut 049-03-3647 88 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Calvert Dunkirk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20754 USA 2625 Marilyn Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: White 1 ☐ Yes 2 🔀 No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma W. Goodall မ John Arthur Clarkson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 Marilyn Lane Dunkirk, MD 20754 Robert E. Madel/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department or Important: If i any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home pe 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed for use as the burial-trar Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Phknown Were autopsy findings available prior to completion of cause of page 2 has autopsy performed? Yes 22 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only on Medical Certification: To Be Other: 4 Nursing Home SPResidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Injury death. 2 Accident investigation 1 □ Yes 2 □ No after death filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) FFB 0 7 2008

0

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70

29c. License number

20646 Krishan Mathur, M.D.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FE'B EONA 18:36 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 🗓 F 85 Yrs. 218-12-5958 09/29/1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery 1 Yes 2 No Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 321 N. Summitt Avenue, #2A 20877 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simmons Clarence 0ra Buser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13645 Old Annapolis Rd, Mt. Airy, MD Sandra J. Price / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Hillcrest Mem. Park 102/19/2008 Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4°Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1∐ Yes 2 □ No 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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r than "natural", or Items 23a or 28a-f shor the Medical Examiner must be notified at

within 72 hours after death

d 2 should be filed w h and Mental Hygiel 7 is marked other tt

permit. Pages 1 and 2.0 Department of Health at Important: If item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

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and attending physician for the ģ has page 2: certificate this death.

Be 2

Physician/Medical Completed

I Director: After to d in by the funera Certification: o the Funeral Dire

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To the Hospital or Attending Physician:

State Registrar

Medical

31. Date filed (Month, Day,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 phpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and addre person who compeleted cause of death (Item 23a) (Type, Print)

D

Year

5

FEB 2

32/19 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Hea		•		
			1 = State Registrer Certificate of De			.No.2008	05556
ı	Dhusisi	26	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		James Francis Mortzfeldt		February	16, 2008	11:48 A M
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo 255 Maryland Avenue Hancock	ocation of Death		4c. County of Dea Washingto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	f Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		220-28-9213 X 2 74 Yrs.	Hours Min.	September 2	29 , 1933 i	MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	h the Marylan	to	MD Washington Hancock				TY Yes 2 □ No
	hours after death with the Maryland turel', or Items 23e or 28e-f ahow al Examinet roust be notified at	Director	10e. Street and Number 10f. Zip Code 255 Maryland Avenue 21750		_	. Citizen of What Co	ountry?
	eath w	erai	•	ania Origin? (Spe		14. Race - Ame	arican Indian
0	r item	Funerai	Armed Forces? If Yes, specify Cuban, I	Mexican, Puerto	Rican, etc.)	Black, Whi	
2	iral", o	by	3 Widowed 4 Divorced It Yes, Give 1 Yes 2 No 5 Year or Dates 1951-1955	Specify:		Specify: Whi	ite
9500-61212	be filed within 72 hours after death with that Hydione. Ind other than "natural", or Items 23s or event, Its Medical Examinational De	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done durit (ifte, DO NOT use retired)	on ing most of worki	ng 16	b. Kind of Business	/industry
717	filed within 72 Hygiene. ther then *nat int, the Wedica	omp	Elementary/Secondary (0-12) College (1-4or 5+) 12 1 Lab Technicia			and Minin	a
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yland	should be nd Mental nmarked umatic ev	To E	William Mortzfeldt	Helen L	ogan		
Mar	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke injury or other traumatic 8.		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mary Ann Mortzfeldt/wife 255 Maryland Ave				Zip Code)
	s 1 and of Healt item 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)			c. Location - City or	Town, State
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saltimore,	permit. Page: Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of			ain Stree	
n	80 = 8 9		Grove Funera				
	*: <u></u> ≉.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.		•		Approximate Interval Between Onset and Death /
ş.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Death (Column Laborator Labo	Can	ano	ma	Smonth
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_	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
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Š	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1			23d. Date of de Month	livery Day Year
5	he death the atter thed for u	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown			WORTH	Oay 16a1
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Spios	quires an sign	ed by			1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown
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5	g Phys er this eral di	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of 28c, Injury at		ne Residenc 28d. Describe how	e 6 □Other (Spe injury occurred	poify)
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<u> </u>	or Atto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stree City or Town, S	t and Number or Ri State)	ural Route Number,
ַ	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely lilled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, or	date and place.	and due to the caus	e(s) and manner a	e stated
	ne Hos ne Fur netely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ion, death occurre	ed at the time, date	and place, and due	e to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier 29c. License nu	umber	29d.	Date signed (Mont	th. Day, Year)
			The flaudon MD DH6	473	<i>[-</i>	eb.1	8, 2008
	W.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CT.	Hadas	Anin	MI DITTIO
*	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	(1,)	Haraker	DIEWII,	110 01170
	Registr	-	FFR 2 5 2008 Brown & South				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Z U U 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Neidert Physician Month Year 6:05 PM 2008 Vancy -ebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Itospita 1 Hopkins The Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10M 20F Yrs. <u> Virginia</u> 233-94-5599 51 West Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathl and Mental Hygiene. Ansit if item 27 is marked other then "naturel", or items 23a or 28e-f show any or other treumalic event, I'm Medical Enginer must be notified at my or other treumalic event, I'm Medical Enginer must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X□Yes 2□No Director Maryland Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4780 Jatbird Court 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ऄ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌡 ☐ No White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Project Manager Free State Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Byron Joseph Bishop Virginia Katherine Fish Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Neidert/ Husband 4780 Jaybird Ct. Waldorf, Maryland, 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: if any injury or once. Mt. Calvary Cemetery 02/09/2008 Wheeling, W.V. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home HO1362 21. Signature of Fuperal Servica Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolism **Physician** day monary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit o the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2-10 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ampatient ၉ 1 | Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a

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completely filled 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St., Baltimore, MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 8 2008

32. Registrar's Signature

Electron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Voor **Physician** 1:00 pM Yousef Niami February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7401 Westlake Terrace, #1402 Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Director 662-03-3659 77 December 22,1930 Iran Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2KINo Director Maryland Montgomery Bethesda 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7401 Westlake Terrace, #1402 20817 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 If Yes, Give Year or Dates: 2 🕱 No 1 ☐ Yes 2 ☒ No Specify. Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrator Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saifedin Niami Monavar Golgoun 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Farhad Niami - Son 7401 Westlake Terrace, #1402, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02/08/2008 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 2 months /Medical Due to (or as a consequence of) Examiner Interstitial Pulmonary Fibrosis 3 years Sequentially list conditions Examiner Due to or as a consequence of: Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) Home Hospice 1 ☐ Yes 2 ▼ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 attending physician the for use page 2 s or Attending Physician: this After after death Director: Hospital e Funeral I

death with the Maryland

Baltimore, Maryland 21215-0036

the To the Within

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29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

and manner stated.

56065MD

February 7, 2008

Carlos Emilio Picone, M.D., 5530 Wisconsin Avenue, Suite 930, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) FEB 08

State Registrar

Medical

4 Homicide

29a. Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itemstate per dyr 8876.2-20-08 yet ealth and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 2008 NEAU Alko N 1853 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 200 77 Director 218-34-0005 February 9, 1930 Japan Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b County 10d. Inside City Limits 1X Yes 2 No Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 124 W. Aztec St. 21001 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: Asian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ransome (Husband) 124 W. Aztec St. Aberdeen, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Baker Cemetery 2/12/08 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Ligenson 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Sance Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4-YSPUL /Medical Due to (or as a consequence of): **Examiner** COLUMNY An PERY Sequentially list conditions, frank leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of Examine The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown OBSTRUL AVE PULMANAMY 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2□ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Anatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/2008 133050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Bernhard Birnbaum Harford Memorial Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State EB 2 5 2008

Registrar

			1 - For State Registrar	State of Mic	ii yiai iu		rtificate of	Death			.2008	05560
	Physici	an	Decedent's Name (First, Middle, Last KATHRYN JAN		IM				2. Date of De	eath	15, 2008	3. Time of Death 12:30A M
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	yland how at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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	with the a or 2 the no	Dire	10e. Street and Number	•			10f. Zip Code	04704		10g. C	itizen of What Co	
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Maryland	should by		Arthur Jacob Sh		r.				ret Lau			
<u>a</u>	d 2 th 8 27 le		19a. Informant's Name/Relationship (Margaret Nusbaum/		ŀ		hawnee D	and Number or Ru				Zip Code)
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ga	permit. Pages 1 an Department of Heel Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer		Por			ss of Facility Ha		Fune	eral Hom	e
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UNISION	pr Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building	injury - At ho , etc. <i>(Specil</i>	ome, farm, st fy)	reet, factory, office			(Street and Nu Town, State)	mber or Rura	l Route Number,
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7	6		30. Name and address of person who		of death (Iten	n 23a) (Type.	Print)	7 1	7-10	0		0
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7	Sta	ite	31. Date filed (Month, Day, Year)	320Reg	istrar's Signa	ature			CITICOII,	31U . Z	.0133	

State Registrar

FEB 2 5 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

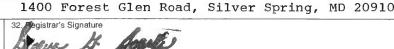
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:00 pM Doris M. Owens February 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 531 Randolph Road, #321 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 M 2 X F Director 579-20-8114 85 August 12, 1922 Minnesota Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 TYes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 531 Randolph Road, #321 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify. ò 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any Injury or other traumatic event, the ones. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Leo Frogh Ethel Marie Sheehan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanne D. Owens - Daughter 322 Mississippi Avenue, Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 02/12/2008 Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. ala 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Congestive Heart Failure Years /Medical Examiner Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 2X No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) P 1 Yes 2X No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation s after death. 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be in 24 hours the Funeral Directory filled in by 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0003792 February 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irnest S. Oser, M.D., 10301 Georgia Avenue, #304, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. egistrar's Signature State FEB 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:05a 2008 /Medical Eloise Hamburger Q
4a. Facility Name (If not institution, give street and number) February 6. O'Neill 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1806 Ladd Street Silver Spring Montgomery If Under 1 Year I If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 ▼ F 448-12-9411 Director 86 23, 1921 Aug. Oklahoma Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f show t be notified at 1 ☐ Yes 2X No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1806 Ladd Street items 23a 20902 USA **Examiner must** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: White Specify: þ 3 ☐ Widowed 4 反 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk FBI permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If item 27 Is marked other
any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Hamburger Marie Rosenoff ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda D. Drake/Cousin 4015 North 152 Avenue, Omaha, NE 68116 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 13, Feb. Greenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Weatherford, Oklahoma 21. Signal re of Juneral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring. Auhard I Hales MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Heart Disease 8 years Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for Month in the past 12 months? Day Year 4⊡Pregnant at time of death 5 Other (specify) 2 No the 9□ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' certificate 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 🔀 Natural 5 ☐ Pending investigation To the Hospital or Attendin-within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D29293 February 8, 2008

State Registrar 31. Date filed (Month, Day, Year) FEB 08

Michael Lincoln, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Evelvn J. O'Brien February 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 6115 Fairbourne Court Hanover Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 86 Director 191-14-1332 January12,1922Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. Cify, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Howard Hanover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6115 Fairbourne Court 21076 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker OwnHome 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Elmer Wees Margaret Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John O'Brien 6115Fairbourne Court, Hanover, Maryland21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-14-08 AdvancedCremationService Boston, Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muhael 6009Harford Road, Baltimore, Maryland21214 Mersul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines or unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Ves 242 No certificate has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending To the Hospinal State death.

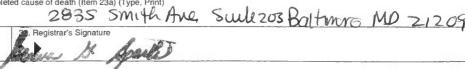
To the Funeral Director: Aff investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

J State

31. Date filed (Month, Day, Year)

FEB 2

5



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

F66Wary 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05565 State Registrar Amend #30, perDVR, g876, 2/19/08 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 8, 2008 **Physician** 1955 James Grafton Osborn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace if Under 1 Year | if Under 24 Hrs. 8. Date of Birth 3/22/1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**⊠**M 2□F Maryland 220-07-7249 Yrs 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 √Yes 2 No Harford Aberdeen Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21001 U.S.A. 626 West Bel Air Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7; Depertment of Heelih and Mental Hyglene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Appraiser Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Jane Grafton James Howard Osborn ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Saluda, VA 23149 28 Dormer Oaks Dr. Mary Helen Morgan (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/13/08 Perryman, MD Spesutia Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Caryo Funeral Home, P.A Aberdeen, Maryland 21001–3399

23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner acquired premana omm Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autonsy 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 2 ER/Outpatient 3 DOA s after death.
I Director: After this of in by the funeral d 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9.2008 00063072 Felorusvu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Apurva Desai, MD. 31. Date filed (Month, Day, Year) FEB 2 5

2008

Harford Memorial Hospital Havre de Grace, MD

Hegistrar's Signature

Amend #19a per FH 02-12-2008 CNM Certificate of Death Reg. No. 05566 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5, 2008 **Physician** 6:06P. M Sidney Allen Perry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 1665 Brittle Branch Way Woodbine If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F 412-88-9609 58 Director Feb. 27, 1949 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1665 Brittle Branch Way 21797 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1969–72 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify. \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within ealth and Mental Hygiene.
n 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Special Agent F.B.I. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lois Simerly Sideny Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Dalrymp Wife Jacqueline Ferry / Husband Department of Health a Important: If Item 27 Is any injury or other trains 1665 Brittle Branch Way, Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/11/2008 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 8 East Ridgeville Blvd., Mt. Airy, MD 21771 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 Years Progressive Nonfluent Aphasia /Medical Due to (or as a consequence of): Examiner Corticobasal Degeneration 8 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? res 24 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No T₀ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054472 February 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Argyl Hillis</u> 600 North Wolfe Street, Baltimore, MD 21287 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan	-	artment of F rtificate of	Health and I Death		jiene eg. No. 2 (008	05567
			Registrar 1. Decedent's Name (First, Middle,	Last)		00.	-		2. Date of Dea	th		3. Time of Death
l.	Physicia	_	Evelyn				Poland		Month 02			2001 M
	/Medic Examin		4a. Facility Name (If not institution,		umber)			or Location of Deat	h	4c. County of Death		
	LAGIIIII		WMHS Braddock	Campus			Cumber	land		A11	egany	
h	Funeral Director		5. Social Security Number 220-30-7827	6. Sex 1 ☐ M 2 🗷 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	Year) 21, 1930	9. Birth Cou	place (State or Foreign ntry) Maryland
			Usual Residence of Decedent									
	uylan show 1 at	L	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 □ No
	e Ma Ba-f s	Director	Pennsylvania	Beaver				Georgetow		0.00		1
	or 2	Dire	10e. Street and Number				10f. Zip Code	1.50.40		10g. Citizen of		-
	ath v s 23a nust	ral		Gibson Hill		6 40	Mac Decedent of L	15043	Pagifu Vas or No.	14 Ra		S.A.
ဖွ	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed	2 📉 No		was Decedent of r If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S ean, Mexican, Puer Specify:	to Rican, etc.)	Spec	ack, White,	, etc.
93	ours iral", Exa	d by	3 N Widowed 4 Divorced	Year or	Dates:							White
2	"natu	Completed	15. Decedent' (Specify only highes	s Education t grade completed	al)	I (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of I	Business/ir	idustry
12	withir	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)	inc.		o, Homemaker			Н	Iome
2	filed w Hygiel other th	ပိ	17. Father's Name (First, Middle, I	_ast)	0				me (First, Middle,	Maiden Surna		
au	2 should be filed w n and Mental Hygie Is marked other t raumatic event, th	o Be	(, , , , , , , , , , , , , , , , , , ,	James Edw	ard Shocker	v	Ellen Adeline Fazer					ker
<u></u>	shoul nd Ma marl marti	မ	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	r, City or Tow	n, State, Zi	ip Code)
Š	1 and 2 Health a tem 27 is		Lynn Rae N	Auir - Daug	hter		17806 O	old Dan's Roo	ck Road, Fro	stburg, M	larylan	d, 21532
Ē,	es 1 a of He of He fitem r othe		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other pla	ice)	Date February 05,	20c. Location	- City or T	own, State
Ë	Pages nent of I int: If its iry or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		m State	Woodl	and Memori	al Park	2008	Alic	quippa,	Pennsylvania
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service I	icensee NeK		2:	2. Name and Address	Eichnorn-Mast Main Stre	1cKenzie Fu	neral Hor	ne P.A.	. 1539
	-		23a. Part L Enter the disease, or	complications tha	t caused the dea	th. Do not en					rand, 2	Approximate Interval Between
	Physician		23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Onset and Death
	/Medical		resulting in death)	a. Due t	to (or as a consec	quence of):	7					
В	Examiner		Comment the tier and distance	h 5.	bacte	MZ						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidenying Cause (Disease or injury that initiated overtex	Due 1	to (or as a consec	quence of):						
	ecuter ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	cate be executed physician and the burial-transit		resulting in deathy East	Due	to (or as a consec	quence or):						
87	cate t	dical		d								
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pto the Funeral Director. After this certificate has been signed by the attending pto completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	1 □Liv	outcome pf pregn e birth 2 Fet egnant at time of known	al death 3[□Ectopic pregnand □ Other (specify) _	су		1	Date of deli	very Day Year
Division or Vital Records, P.O.	res that I igned by be detar		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to the cause of death? Yes 2 1 no 3 Probably 4 □Unknown		
O	requi	eted	CZI Flogeric S	(/	2012 12 -	(6)	- E , very	DO (0-3164				
l Rec	The law ate has t page 2 s	Completed by	respiratory to	. (24a. Was autor perfo 1∐ Yes		prior to death?	topsy findings available completion of cause of
ita	stan: ertific ctor,	Be	25. Was case referred to medical examiner?						eath (Check only o	ne)		
Ž	hysic his co	To	1 Yes 200No			ER/Outpatie	III OLI DOM		Home 5 ☐ Resid			cify)
N C	ing P	ion:	27. Manner of Death 1 Natural 5 □ Pending	9 / <i>(M</i>	ite of Injury Jonth, Day Year)	28b. Time of Injury	Wo	ury at ork? ∃Yes 2 □ No	28d. Describe f	now injury occ	urrea	
isio	death death stor: / the f	icat	2 Accident investig 3 Suicide 6 Could r		ace of injury - At h	orne, farm, st			28f. Location (S	Street and Nur	mber or Ru	ıral Route Number,
<u>></u>	al or A s after al Direct	Certification:	4 ☐ Homicide determ	ined bu	ilding, etc. (Spec	ify)	reet, factory, office		City or Tòv	vn, State)		·
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ledical (29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my kn e basis of examin anner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	H	. /		29c. Licer	se number	0	29d. Date sign	ned (Monti	h, Day, Year)
		/	3 3 m		Mysicie-	m 23a\ /T·	Print	0 211	8	1/2/	ď	-31-11-12-
		2	30. Name and address of person	wild completed ca	ause of death (Ite	/ Sets -	Dr. 60.	- Gerland	MO			
	Sta	ate	31. Date filed (Month, Day, Year)		. Régistrar's Sign	ature	2	2. (-4)				
	Regist	rar	FEB -	5 2008	Aleksen	15 1	mosta					

08-01366 Maurice Luther Pea	Please Type or Print in Black Indel	ible Ink. Ensure All Copies Are Legent of Health and Mental Hygiene	
		ata of Dooth	2008 05568
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Maurice Luther Peacoc		Day Year 1511 hrs
5	4a. Facility Name (if not institution, give street and number) 10932 Adkins Road	4b. City, Town, or Location of Death Berlin	4c. County of Death Worcester
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	in chider / tell	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	530-54-7025 13M 2 F 50	Yrs. Months Days Hours Min. 08/26	/1957 Country)
amy	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
St. Kee	Maryland Worcester Ber	clin	1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number	101. 219 0000	log. Citizen of What Country?
lith the same that the same time al Di	10932 Adkins Road 11. Marital Status 12. Was Decedent Ever in U.S.	21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No.	USA 0- 14. Race - American Indian, Black,
or items 23	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
safter of	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify: a Decedent's Usual Occupation (Give kind of work done	Specify: White 16b. Kind of Business/Industry
2 hours "natur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)	Tob. Taria of Basiness/massay
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	11 -	warehousing	Coca Cola Bottling Co
filed w filed w other of the b	17. Father's Name (First, Middle, Last) Maurice Luther Peacock Jr.	18. Mother's Name (First, Middle, Nancy Freemar	
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than ite event, the Median To Be Comple		9b. Mailing Address (Street and Number or Rural Route Nu	ımber, City or Town, State, Zip Code)
MD d 2 sho lth and lth and m 27 is sumati	Linda Fooks/sister	304 Williams St., Berlin,	MD 21811 20c. Location - City or Town, State
Baltimore, MD bemit. Pages I and 2 sho Oppartment of Health and Important: If item 27 is injury or other traumail	1 Burial 2 X Cremation 3 Removal from State crem	natory or other place)	
ti. Pag it. Pag rtment orfant: y or ot	4 Donation 5 Other Specify: Sali:	sbury Crematory 2/20/08	Salisbury, MD
Ba perm Depa Impo	Day Holla	22. Name and Address of Facility Holloway Funeral Home Pr 501 Snow Hill Rd., Salis	bury, MD 21804
Physician	28a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		rrest, shock, or heart Approximate Interval Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death) a. Complications of chapter of the condition of the conditio	ronic renal failure	- Dodin
	Sequentially list conditions, b		
ed nisit Examiner	if any, leading to immediate cause. Enter Underlying Cause c.		
bsit sit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
executed an and al - transit	U.	2 ~977 3/11/08 TT	
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial.	#ZJa,PII,Z/,pen'll IF FEMALE: 23c. If yes, outcome of pregnar	cy	23d. Date of delivery
Box 68760, e death certificate be the attending physic cd for use as the bur burst citizan/Moner	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
Box e death the atte	1 Yes 2 No 9 Unknown 9 Unknown		d tobacco use contribute to the cause of death?
P.O. es that the gened by be detach		tang ar are criserying ecoop great are	Yes 2 No 3 Probably 4 ✓ Unknown
ds, I		24a. W	as an 24b. Were autopsy findings available topsy prior to completion of cause of
Records, The law require: ficate has been sign, page 2 should be		pe	rformed? death?
n of Vital Records, ing Physician: The law requir After this certificate has been a funeral director, page 2 should		26.Place of Death (Check only one)	
F Vita Physicia or this ce	1 V Yes 2 No 1 inpatient 2 El	R/Outpatient 3 DOA Other Nursing Home 5 Bb. Time of Injury 28c. Injury at Work? 28d. Descri	Residence 6 • Other: Scene
n of ding Pl	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 2 1 X Natural 5 Pending	Bb. Time of Injury 28c. Injury at Work? 28d. Descri	be now injury document
Division The or Attending and Director: The cip by the first	2 Accident Investigation 28e. Place of Injury - At hom	e, farm, street, factory, office building, etc. 28f. Locatio	in (Street and Number or Rural Route Number, City n, State)
Division o spital or Attending north The Transfer Center or Aft filler in by the fune	Suicide 6 Could not be determined (Specify)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. After death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filler in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To De Completed by Divisional Madical Experience of the completely filler in by the funeral director, page 2 should be detached for use as the burial - transitional Certification:		death occurred at the time, date and place, and due to the color investigation, in my opinion, death occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
To To com	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Pate Q - Polloh r	O.C.M.E.	February 17, 2008
	30. Name and address of person who completed cause of death (Item 2 Patricia Aronica-Pollak MD. Assistant Medical Ex		201
Sta			
Registr	e 31. Date filed (Month, Day, Year) 7 2008 32. Resistrar's Signature FEB 2 0 2008	C. Agence	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryland		artment of H		nd Mer		ne (08	055	69
u		8	Decedent's Name (First, Middle	, Last)						Date of Death			3. Time of	Death
	Physici /Medic		Theresa 0)reste	Pirrone					Month ebruary	Day 15	2008	545	m M
	Examin		4a. Facility Name (If not institution	, give street and nu	umber)		4b. City, Town, or	Location of			4c. County			·
			St. Catherine's	Nursing	Center		Emm i t	sburg	ı		F	reder	ick	
П	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days		4 Hrs. 8. Min.	Date of Birth (Month, Day, Y	(ear)	9. Birthp	lace (State of	r Foreign
	Director		053-01-6060	1 □ M 2 💢 F	92	Yrs.	MONITS Days	Hours	J	an. 3,	1916		York	
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10- 0'-	T						14	04 1 14 01	
	aryla shov	_			TOC. City	, Town of Lo	ocation					1	0d. Inside Cit 1 ☐ Yes	•
	8a-f	ecto		roll			Mt. A	iry						-×''
	vith ti	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of	What Coun	itry?	
	death with the Maryland ms 23a or 28a-f show rmat be notified at	rai	2514 Vance					1771		И И		.S.A.	1 . 4'	
	after de or Item miner	Funerai	11. Marital Status	Armed F		5. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origi n, Mexican,	Puerto Rica	y yes or No- an, etc.)		ce - Americ ck, White,		
5	rs aft	by F	1 Never Married 2X Marr 3 Widowed 4 Divorced	If Yes G	2 🔀 No live Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specif	fy: July :	4.0	
2-003p	hours a		15. Deceden		Dates.	16a Dece	dent's Usual Occupa	ition		16	b. Kind of B	Whi		
<u>.</u>	within 72 ene. than "nat	Completed	(Specify only highes	st grade completed,		(Give	kind of work done d DO NOT use retired)	urina most d	of working	10	D. 14114 01 0	2011000	245119	
	iene iene	E O	Elementary/Secondary (0-12)	College	(1-4or 5+) 2	nub1	ication e	ditor		F	Endara	1 σον	ernmer	n#
0	be filed within 72 hours after death with the Marylan nal Hygtiene id other than "natural", or liems 23a or 28a-f show avent, the Medical Evantinar must be nulliked at	Be C	17. Father's Name (First, Middle,	Last)		pus.				irst, Middle, Ma			ernmer	10
<u> </u>	should be nd Mental markad o	To B	Salvatore Ore	ste				An	gelin	a Pitti				
ary	permit. Pages 1 and 2 should b Department of Health and Ments Important: if Item 27 is marked any injury or other traumatic e once.	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a					, State, Zip	Code)	
≥	nd 2 ulth a 27 is r trau		Anthony Pirrone	/ husban	d	2514	Vance Dr.	M+	. Air	y, MD 2	1771			
<u>6</u>	F Heal		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of		Date		c. Location	- City or To	wn, State	
Saltimor	age: ent o nt: If y or		1X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S		1 State		natory or other place leaven Cen		10/20	08 si	1,405	Conin	a MD	1
	nit. Fartmontartmontartminjur		21. Sign fur of Funeral Service		1a		2. Name and Addres						g, mu	
ă	permi Depa Impo any ir		Matharine ((), Xar	Pler		1802 Libe						1762	3
v			23a. Part1. Enter the disease, or	complications that	odused the death							MD Z	Approximate	9
l,			shock, or heart failure. List Immediate Cause (Final	only one cause on	line.	- 1	0 4	- 1 -	-	-			Interval Bet Onset and I	ween Death
	Pnysician /Medical		disease or condition resulting in death)	a	Mulli	. Vu	farci	Ne	men	les		-	Syes	us
	Examiner			171	(r as a consequ	ence or):	1 Ca	1 -	1101	. 0.	Na	00.0	10	4.4
		e	Sequentially list conditions,	b	(or as a consequ	price of j	oue co	MACLE	vasc	uls-		ore	10.9	9
/	uted I Insit	Examin	cause. Enter Underlying Cause (Disease or injury		Ĭ.	June	A Caral						3/1 11	ONIA
,	exection and in all-tra	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence (i)			<u></u>				- Cry	~(.~~)
0/ p	cate be executed physician and the burial-transit	cail				3							•	
9	ificate g phys as the	edi		G										
X D D	nding use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar						23d. Da	ate of delive	ery	
Ď	death e atten ed for u	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2□Fetal mant at time of de		Ectopic pregnancy Other (specify)				1	onth	,	/ear
	the c by the ached	nysi	9 Unknown	9□ Unkr	nown									
T	The law requires that the death certific tte has been signed by the attending rage 2 should be detached for use as	by P	Part II. Other significant condition	ns contributing to	death but not resu	lting in the u	nderlying cause give	n in Part I.		23e. Did toba	cco use con	tribute to th	ne cause of d	eath?
ds,	quire; n sig									1 🗆 Yes	2 🖪 No	3 ☐ Prob	abiy 4 □U	Jnknown
ecol	w rec	jete								24a. Was an	24b.	Were auto	psy findings	available
e L	he ta e has	Completed								autopsy performe	d2	prior to con death?	impletion of ca	ause of
VII GII		e C	25. Was case referred to medical								No	1 🗆 Yes	2∐ No	
	Physiclan: this certific ral director,	o Be	examiner?	Hospital:	Inpatient 2 🗆 E	0.0	Othe	-		heck only one)	a Mos	/0		1
5	Phy or this oral d	\vdash	27. Manner of Death	28a. Date		28b. Time of	it 3 DOA	41 Nurs		5 🗋 Residend			7)	
5	th. : Afte	tio	1 Natural 5 Pendin 2 Accident investig	9	nth, Day Year)	Injury	Work	? ′es 2 ☐ N	1					
UNISION	dea ctor	ertification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At hor	me, farm, str			-	Location (Stre	et and Num	ber or Rura	l Route Num	ber,
5	after Dire	erti	4 Homicide	build	ding, etc. (Specify,)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,	State)			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	alc	29a. Certifier 1 Certifyin	g Physician: To th	e best of my know	vledge, deat	h occurred at the tim	e, date and	place, and	due to the cau	se(s) and m	anner as s	tated.	
	e Ho 124 h e Fu letely	edical	(Check only 2 Medical one)	Examiner: On the l	basis of examinati nner stated.	on and/or in	vestigation, in my op	oinion, death	occurred a	at the time, date	and place	, and due to	the cause(s)
	To the To the Somp	Me	29b. Signature and title of certifie	h ()	11	0 1	29c. License	number		290	I. Date sign	ed (Month.	Day, Year)	
			• (,	U.	- Cour	1	MI I	1187	05		21	18/1	78	
	(0		30. Name and address of person	who completed cau	use of death (Item	23a) (Type.	Print	3101			-	10.10	- 0	
	Ψ		Alan Carroll		310 S.				Emmi	tsburg,	MD 2	1727		
-	Sta	té	31. Date filed (Month, Day, Year)	1 29	Registrar's Signat		and a							
	Registr	ar	FFR 2 5	5 2008	inever &	The first	MARI!							

PRITCHETT, MILDRED

			For State Registrar	Otate of Mai		ertificate of			g. No.) (33/1		
- 2	, s	-	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	n Day Year	3. Time of Death		
Н	Physicia /Medic	~	Mildred Cather:	ine Pritche	tt			Feb. 16		17:35 [™]		
	Examin	- 2	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Deat	h		
		ш	Dorchester Genera	al Hospital	-		Cambridge			hester		
	Funeral Director		5. Social Security Number 6. S 214.12.6704	THE OFF	(In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 17,	Year) 9. Birt Co	hplace (State or Foreign buntry) ryland		
	Þ		Usual Residence of Decedent							10d. Inside City Limits		
	arylar show d at	ŗ.	10a. State 10b. County		10c. City, Town or L					1 Tyes 2 No		
	Ba-f	Director	Maryland Dorch	ester	W	ingate		10	og. Citizen of What Co			
	a or 2 be n	흡	10e. Street and Number	ma na	1	10f. Zip Code 216	75		US	•		
	eath rs 23 must	eral	2147 Wingate-Bish	12. Was Decedent Ev				ecify Yes or No-	14. Race - Ame			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ Ho	an, Mexican, Puèrto Specify:	Black, White, etc. Specify: White				
Š 2	72 hor	Completed	15. Decedent's Ec	lucation de completed)	16a. Dec	edent's Usual Occu	oation during most of work	kina I	16b. Kind of Business/	Industry		
7	ithin 7 e. • Med	ם	Elementary/Secondary (0-12)	College (1-4or 5+) [e kind of work done DO NOT use retire		9	Shellfi	ah		
2	filed w Hygier ther th	ខ	17. Father's Name (<i>First, Middle, Last)</i>) 3	eafood Wo		e (First, Middle, M		SII		
and	he fi	Be	• • • • • • • • • • • • • • • • • • • •				'	encie C.	,			
ž	should I and Men s marke umatic	으	James Thomas To		19h Mai	ling Address (Street			City or Town, State, 2	Zip Code)		
Z S	nd 2 sho Ith and 27 is ma trauma		Doris E. Windsor/		I	-			, Wingate,			
a,	ss 1 and of Health Item 27 other tr		20a. Method of Disposition			oosition (Name of ematory or other pla	-		20c. Location - City or			
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o		1		1	erMemoria		9.2008	Cambridge	, MD		
ati	mit.		21. See ture of Fune of Fune vice Licer			22. Name and Addre	ess of Facility					
<u> </u>	S I L L	10	rouseen Herry	- 180mill	sell!	Curran-Br 308 High	St., Camb	ridge, M	D'21613			
			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not e	nter the mode of dy	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
8	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Isc	haenic	Bowel				Cristiana Boati		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	0 - 1		2 - 0				
	74	<u></u>	Immediate Cause (Final disease or condition resulting in death) a. ISChaeuric Bowel Due to (or as a consequence of): Ar ferro sclewic Cordivorscular disease b. Due to (or as a consequence of): Due to (or as a consequence of):									
$\sqrt{}$	nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ď	exectin and iaf-tra	Examiner	resulting in death) Last	CDue to (or as a	consequence of):							
68760,	tificate be executed ig physician and as the burial-transit	ical		d								
	rtifica ng ph as th	Med	IF FEMALE:									
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey .		23d. Date of de Month	livery Day Year		
	s that ned b e deta	by Pr	Part II. Other significant conditions	ontributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?		
g	quire en sig uld bu							1 □ Y€	es 2⊠No 3∏P	robably 4 Unknown		
Records,	aw re is bee 2 sho	Completed					_	24a. Was ar	n 24b. Were a	utopsy findings available completion of cause of		
_	The lav ate has page 2:	E O						perforr	ned? death? 2 ☐ No 1 ☐ Yes			
Vital	clan: ertific ctor,	Be (25. Was case referred to medical examiner?					th (Check only on	e)			
<u></u>	hysik this o	은	1 ☐ Yes 2 ☐ No	Hospital: 1 patien		BIIL SELDON			ence 6 □Other (Spe	ecify)		
Division or	or Attending Physiclan: The lifter death. Director: After this certificate he in by the funeral director, page	ii O	27. Manner eath 1 4 atural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	· Wo	ıryat ırk?]Yes 2 ☐ No	28d. Describe no	ow injury occurred			
2	l or Attencatter death Director:	icat	2 Accident investigation 3 Suicide 6 Could not b		v - At home, farm, s	street, factory, office		28f. Location (St.	reet and Number or F	lural Route Number.		
2	lor A after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,,,		City or Town	n, State)			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C		nysician: To the best of miner: On the basis of and manner state	examination and/or							
	To the within 2 To the complete	Me	29b. Signature and title of certifier	(6.4		29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)		
	,		Jaie	WHY HID		D	17924		2-17-08			
	5		30. Name and address of person who	503	ath (Item 23a) (Type		INCE >	10 21	613			
12	Sta	ate	31. Date filed (Month, Day, Year)	32. Registral		- Melitic	1966	,	015			
	Registi	_	FEB 2 5 200	8 Alexan	15 April	W.						

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State of Maryland / Department of Health and Mental Hygiene 2008

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 105AM 2008 William Raupach 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lions Center for Rehabilitation Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 12, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days Months 1 M 2 □ F 218-16-4344 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count ms 23a or 28a-f shov must be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 N. Liberty Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items: any Injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: Be Completed by 3 ☐ Widowed → Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Service Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edgar Raupach Rose Wagner Raupach ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5223 Marcella Ct. Durham NC 27707 19a. Informant's Name/Relationship (Type. Print)
Donna Ogilvie daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/18/2008 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 11 23a: Part1. Enter the diseas polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final disease or condition resulting in death) **Physician** 1 wee /Medical Due to (or as a consequence of) Examiner)ementio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Disease burial-tran Due to (or as a consequence of): physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy after death.

Director: After this certification in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours aft

To the Funeral Di

completely filled in

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) FEB 2 5

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SETON DR

29c. License number

29d. Date signed (Month, Day, Year)

SUITE 2030 UMBERLAND, MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 16,2008 ELIZABETH EVA ROWE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Medical Social Security Number Year Date of Birth (Month, Day, **Funeral** Days Min Year 18,1933 1 □ M 2√2 F 74 MAY 213-38-1903 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at Director MD. CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number P.O.BOX 2229 20646 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Department of Heatth and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER CHAS.CO.BD. OF EDUC. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REV. JULIAN E. McDONALD HIAWATHA E. DUVALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RAYMOND L. ROWE-SPOUSE P.O.BOX 2229 LA PLATA, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 Method of Dispusition 3 Removal from State TRINITY MEM. GARDENS Pages 2-20-08 WALDORF, MD. 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. M00479 21. Signature of Funeral Service Licensee LA PLATA, MD. 20646 ucha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Examiner Physician/Medical þ Completed

Be

Certification: To

Medical

physician and s the burial-transit

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signed by t

certificate has

After this funeral

filled in by the

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Box 68760.

P.0.

Records,

Division or Vital

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 200 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

2 No

1 ☐ Yes

27. Manner of Death 1 Et Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 4☐Pregnant at time of death

28a. Date of Injury (Month, Day Year)

and manner stated.

Due to (or as a consequence of):

1 ☐ Inpatient 2 ☐ ER/Outpatient

3 □Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Day

23d. Date of delivery

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and (1) e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be determined

5

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

23e. Did tobacco use contribute to the cause of death?

Approximate Interval Between Onset and Death

3. Time of Death

10d. Inside City Limits

1 ☐Yes 2 No

 \boldsymbol{H} M

Year

MD.

14. Race - American Indian,

Specify: WHITE

20646

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or nother traumatic event, the Medical Examiner must be notified at	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Tuenstan Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	

Physic /Medi Exami

Funeral Director

		For State Registrar			Certificate of		Reg. I	4 mag.	3. Time of Death
ysici	an	Decedent's Name (First, Middle, L					Month	Day Year	M
Medic	-4	Pearl J. Re			4h Cihi Town o	r Location of Death	February	7 10,201 4c. County of Dea	
xamin	er	4a. Facility Name (If not institution, g					1_		
lt-residen		3320 Curtis D 5. Social Security Number 6.		3 ge (In yrs. last birt	Marlov hdav) If Under 1 Year	W Height If Under 24 Hrs.	8. Date of Birth	rince (thplace (State or Foreign
neral ector		227 – 44 – 2894 Usual Residence of Decedent	1 □ M 2 □ X F		Yrs. Months Days	Hours Min.	(Month, Day, Ye Jan.16,		ountry) VA
		10a. State 10b. County		10c. City, Town	or Location	_			10d. Inside City Limits
ed a	힏	DC		Was	hington				1 X Yes 2 No
notif	Director	10e. Street and Number	10g.	Citizen of What C	ountry?				
of be	0	336 37th St.	SE #204	1	200	19	U	nited S	States
m .	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decedent of H If Yes, specify Cub			14. Race - Am Black, Whi	erican Indian,
important in the manner of the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ☐ Divorced		Č No	1 ☐ Yes 2 ☑ No		, , , , , , , , , , , , , , , , , , , ,	Specify:	ack
edicalE	Completed	15. Decedent's (Specify only highest of	rade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work		. Kind of Business	s/Industry
Je M	ᇤ	Elementary/Secondary (0-12)	College (1-4or	5+)	Cashi	er	6	iant Fo	hod
in, th		17. Father's Name (First, Middle, La	st)		Casiii		e (First, Middle, Mai		7.00
e ve	Be c	Harry Jones				Matild	a Black	well	
matle	은	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Address (Street	and Number or Ru	ral Route Number, Ci	ty or Town, State,	Zip Code)
trau		Charlene Flet		thter i	3320 Curti Marlow Hei Disposition (Name of ry, crematory or other pla	s Drive	a#193746		
other	6 11	20a. Method of Disposition	enery dade	20b. Place of	Disposition (Name of	gnus, M	Date 200	. Location - City of	r Town, State
yor		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		·	oln Mem. C	,			ь ма
in in		21. Signature of Funeral Service Lie	-	Dince	22. Name and Addre	ess of Facility H	odges &	Edwards	F.H.
any		Danna	How or	1			_		1,Md.20746
200		23a. Pa ty. Enter the disease, or co sh k, or heart failure. List or	mplications that aus	ed the death. Do					Approximate Interval Between
ician		Immediate Cause (Final							Onset and Death
dical		disease or condition resulting in death)		is a consequence	ell Lung C	ancer			
niner									
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a consequence	of):				
ansit	Examiner	Cause (Disease or injury that initiated events	c						
ial-tr	Exa	resulting in death) Last		is a consequence	of):				
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as the burial-transit				-		-		======	
10 the Futheral Director: After this certificate has been signed by the arentomic completely filled in by the funeral director, page 2 should be detached for use.	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 ☐ No		2 ☐ Fetal death at time of death	3 □Ectopic pregnand 5 □ Other (specify) □	су		23d. Date of d Month	lelivery Day Year
etach	Phy	9 ☐ Unknown Part II. Other significant condition	s contributing to death	but not resulting i	n the underlying cause of	iven in Part I	23e. Did tobac	co use contribute	to the cause of death?
uld be d	by	Part II. Other significant condition	s contributing to death		The underlying cause gi				Probably 4 Donknown
e 2 sho	Completed						24a. Was an autopsy performe	prior t	autopsy findings available o completion of cause of
, pag	ပိ							No 1LIY	es 2 No
ectol	Be	25. Was case referred to medical examiner?	Hospital:		utnationt SCI DOA OI	ther:	ath (Check only one)	o 6 1004 (2	Daughter
al dir	은	1 Yes 2 No	1 ☐ Inpa		upatient 3 DCA	4 🗀 Nursing F	lome 5 Residence 28d. Describe how		Hoūse—
funer	io io	1 □ Natural 5 □ Pending	(Month, I		Injury Wo	ork? ∐Yes 2 ∐No		,	
n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	t be 28e. Place of	injury - At home, fa etc. (Specify)	arm, street, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
ely filled i		(Check only 2 Medical E	xaminer: On the basis	s of examination a	e, death occurred at the nd/or investigation, in my	time, date and place opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner e and place, and c	as stated. due to the cause(s)
me Tiplet	Medical	one)	and manner	stated.		nse number		. Date signed (Mo	
000	2	29b. Signature and title of certifier	& How	try	1	30188	200		3/08
		30. Name and address of person w	ho completed cause of	of death (Item 23a)	(Type, Print)				
		Sara L. Horto	on, MD. 1	10 Irvi	ing St., N	W #2200	,Washing	ton,DC	20010
² St	ate	Sara L. Horto	2008 32 Regi	strar's Signature	book			<u> </u>	
Regist	trar	red 4 J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ORENCE ROHMER 12-00 AM 04 2008 FER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTTHORE NWGIZ HOLPITAL AN DALL NORTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 11/30/1930 1 ☐ M 2 🛛 F 216-32-4127 77 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes XX No MD Baltimore Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 USA 3501 Hernwood Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Vesper Elizabeth Bush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Strohmer/Husband 3501 Hernwood Rd., Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Family Cemetery 2/8/2008 Randallstown, MD 2Bumsier-Queen Funeral Home & Crematory, P.A. 21. Signature of Funeral Service icense 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a surrecyclence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical **Examiner**

artment of Health and Ment ortant: If item 27 is marked Injury or other traumatic

permit. Page Department of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

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Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

sician and burial-tran attending physician the ed by the a certificate has been signed by rector, page 2 should be detact

Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. within 24 hours a

Division or Vital Records, P.O. Box 68760,

WJL 1

in the past 12 mo 1 ☐ Yes 2 X N 9 ☐ Unknown		4	Pregnant at time of a			pecify)	-			Month	Day	Year
Part II. Other significa	nt conditions co	ontributing	g to death but not res	sulting in the unde	rlying	cause given in Part I.				se contribute		use of death? 4 ∐Unknow
									opsy ormed?	24b. Were prior to death'	o completi ?	ndings availabl on of cause of No
25. Was case referred	to medical					26. Place of De	ath (Check only	one)			
examiner? 1 ☐ Yes 2 ☑ No		Hospital:	1 Inpatient 2	ER/Outpatient	3□ D	OA Other: 4 Nursing	Home	5 ☐ Res	idence 6	□Other (Sp	necify)	
27. Manner of Death 177 Natural 2 ☐ Accident	5 ☐ Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	280	d. Describe	how injury	occurred		
3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e.	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		iner: On				d at the time, date and placen, in my opinion, death occ						
29b. Signature and title	e of certifier				29	c. License number			29d. Date	e signed (Mo	nth, Day,	Year)

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSPITAL CENTER

31. Date filed (Month, Day, Year)

32. Registrar's Signature

CEDDIVARI

FEB 0 6



Registrar

5401 OLD COURT ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year :45 PM LEWIS tricin FEHRUARY 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Brighton CHASE Friendship EVY GARDENS MONTGOMERY 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Rhode Island 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Hours Davs 1 □ M 2 🛣 F Months May 10, 1929 78 039-18-0221 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10h County 1 X Yes 2 □ No Director Palm Beach Delray Beach FL10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 33483 50 East Road #9E Barr Terrace Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Art Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wood Edward T. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4550 N. Park Avenue #811 Chevy Chase, MD 20815 Lisa Larracuente/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 02/09/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Sen MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Duct Bile disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

for use as the burial-transi Box 68760. attending physician requires that the death certificate be Physician/Medical signed by the sid be detached in P.0. detached or Vital Records, Completed by page 2 : certificate Physician: director, Be 2 this funeral Certification: After Division death. To the Hospital or Attence within 24 hours after death To the Funeral Director: the f filled in by Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show at a or 28a-f sho t be notified a

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with

death

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itei

27 is marked other than "natur traumatic event, the Medical

permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once.

Physician

/Medical

Examiner

and

Baltimore, Maryland 21215-0036

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Year) Day, 31. Date filed (Month. FEB 2008

MORRISON

29b. Signature and title of certifier

29a. Certifier

(Check only

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN MORRISON 5410 Connectic T Ave

5410

📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO 30247

29d. Date signed (Month, Day, Year)

08

NW WASHINGTON DC 2000)

2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 VONTOR /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** WICOMICO SALISBURY THE Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral 1** M 2□F Months Hours Min. 0 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 (No Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lesman Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation SALISBURY MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHOLAN GIO CARCINOMA **Physician** disease or condition resulting in death) MRTASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy ŏ 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 XNo Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Medical Certification: To 0 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Atternwithin 24 hours are death To the Funeral Lirector filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

e e e e e

State Registrar 31. Date filed (Month, Day, Year)

P.O BOX 1737 SALISBUTY mp. 2182

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

COASTAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month 2 **Physician** SWINK ERNARI) 0534M 06 08 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Jan. 5 6. Sex Birthplace (State or Foreign Country) **Funeral** Year Months Yrs. Maryland Director 213-22-2493 79 1929 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 XX es 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e ral", or items 23a Examiner must b 1203 Sterling Drive 21403 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces?

▼☑Yes 2☐No 1951-14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married XX Married altimore, Maryland 21215-0036 1 ☐ Yes 🏋 🛱 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) District Court of Elementary/Secondary (0-12) College (1-4or 5+) Supervisory Commissioner Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Emory Washington Swink Nellie Leona Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Mason Swink / Wife 1203 Sterling Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: if ite any injury or ot 1 Drurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Gardens 2/9/2008 Annapolis, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mie 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FIBRUSIS I DIOPATHIC Immediate Cause (Final Physician mos ULMON resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or sela consequence or): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a ☐Yes 2☐No 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X**No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has break rector, page 2 s autopsy performe or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 5 ☐ Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Breary Of,

Registrar

State

FEB 0 8 2008

Name and address of pi

31. Date filed (Month, Day,

Gerow & Sport

(Item 23a) (Type, Print)

DEFENSE HEAWAY ANNAPOUS MP 2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dау Month :52 **Physician** AROLD -2008 m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18004 Oldtown Rd. SE Oldtown Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 8, 1929 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F Μ̈́D 213-24-6986 Director 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count show at Oldtown MD Allegany 1 ☐Yes 2 ☐ No "natural", or items 23a or 28a-f sh dical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21555 18004 Oldtown Rd. SE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ **X**o Baltimore, Maryland 21215-0036 Specify Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "natural other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry buld be filed within. Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) B&O/CSX Railroad carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leafie L. Shrout unknown t and 2 should by Health and Ment ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18004 Oldtown Rd. SE Oldtown MD 21555 **Betty Shrout** wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of He
Important: If Iter
any Injury or oth 1

■ Burial 2 □ Cremation 3 □ Removal from State **Davis Memorial Cemetery** 2/17/2008 MD Cumberland 4 ☐ Donation → 5 ☐ Other (Specify) 21. Signature of Foneral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm late Cause (Final Cerebro Vasa YVS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a conse wence of] Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2∏No 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Naccident 5 Pending investigation n 24 hours at er death.

Re Funeral Director Affolgetely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 00033280

State Registrar

DHMH 17 Rev 1/2001

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SUNIL GUPTA
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

AVE CUMBERLAND, MD 21502

3-01137	_	Please Type or Print in Black Indelible			ible.		
arion Smith, J		State of Maryland / Department of 1-For State Registrar Certificate of Maryland / Department of Certificate of Certificat		Reg	. No. 200	8 0557	
Physici ledical Exam		Decedent's Name (First, Middle,Last) Marion Smith Jr		2. Date of Death Month February 9,		3. Time of Death 0056 hrs	
		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital	4c. County of Death Prince George's				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth					
Director		248-98-5280 1 M 2 F 54 Y Usual Residence of Decedent	rs. Months Days Hours Mir	Aug.23	Foreign Cou Was	sh.,DC	
w any		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits	
daryland 28a-f show any 1 at once.	ctor	Md. PG Camp	Springs 10f. Zip Code	100	g. Citizen of What Count	1 X Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once.	Director	5220 Carswell Ave. #204	20746	105	United St	•	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teelth and Mental Hygiens them 27 is marked other than "natural", or items 23a or 28a-f 5the traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? If	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.		
after d al", or	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Date:	Yes 2 X No specify:		Specify: Blac	ck	
hours 'natur		15. Decedent's Education (Specify only highest grade completed) 16a. Deceded during	ent's Usual Occupation (Give kind of most of working life, DO NOT use ret		16b. Kind of Business/In	dustry	
136 thin 72 ne. than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Sale	s Representati	VA	Privat	-0	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		(First, Middle, Ma	aiden Surname)	<u></u>	
2121 ild be f Mental marked event,	To Be	Marion Smith Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Odeath Odeath	ar Sco	ott Der City or Town State	Zin Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene, Important: If them 27 is marked of her than 's highery or other traumatic event, the Medical.	٦	Serina Smith/wife 522	ng Address (Street and Number or 0 Carswell Ave p Springs, Md.	· #204 20746	or, only or rown, orace,	2.p 000e)	
s l and of Heal		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition Removal from State	osition (Name of cemetery,	Date	20c. Location - City or T	Town, State	
altimore, mit. Pages 1 ar partment of Hea portant: If ite ury or other tr		4 Donation 5 Other Specify: Resurre			Clinton,		
Ball permit Depart Impor		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Ho 910 Silver Hil	dges &	Edwards E	F.H.	
Physician		23a / art I. Enter the disease, or complications that caused the death. Do not enter / failure. List only one cause on each line.				Approximate Interval	
/Medical xaminer	is UN	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Di	sease			Between Onset and Death	
		or condition resulting in death) Due to (or as a consequence of):					
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			. 63		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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	ledic	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			Tool Date of delivery		
687(ertifica ding ph	sician/Medi	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year	
30x 687 death certific te attending p	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)				
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	by Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to t		
ds, P.(equires that een signed ould be det				1 Yes	2 No 3 Proba		
Division of Vital Records, read or Attending Physician: The law requirant for the carb. After this certificate has been seled in by the funeral director, page 2 should the	Completed		-	autops perforn	y prior to co	opsy findings available ompletion of cause of	
tal Rection: The		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes	s 2 No	
Vital I hysician; this certifi Il director,	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	- Joshan -		Residence 6 Other:		
on of Vital I ending Physician; ath. or: After this certifi the funeral director,		27. Manner of Death 1 V Natural 5 Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Death		28d. Describe ho	ow injury occurred		
Sior	icati	2 Accident Investigation	1 Yes 2 No	28f Location (St	reet and Number or Rur	al Route Number City	
Divisi e Hospital or At 124 hours after d e Funeral Direct	Certification:	3 Suicide 6 Could not be determined (Specify)	oot, lastery, office ballung, etc.	or Town, Sta		ar Rodic Hamber, Oity	
5 7 5 B	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occording one) Wedical Examiner: On the basis of examination and/or investig					
To with To Con	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)	
		Doma midincenti, m.D.	O.C.M.E.		February 9, 2008		
		Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	1 Penn Street, Baltimore, N	ID 21201			
`		31. Date filed (Month, Day Year) 32. Registrar's Signature		10 2 1201			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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State of Maryland / Department of Health and Mental Hygiene []

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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician erua /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND If Under 24 Hrs. 8. D s Hours Min. (A ALLEGANY DEVLIN MANOR NURSING HOME

5. Social Security Number

6. Sex If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□ M 2₽ F 83 Director 06-16-1924 MARYLAND 220-16-6936 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23e or 28e-f show traumetic event, the Modical Examiner must be notified at 15 Yes 2 □ No Directo MD ALLEGANY FROSTBURG 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21532 UNITED STATES 83 MESACH FROST VILLAGE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or itel any Injury or other traumatic event, the Modical Examina-1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 1 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL 12 MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH WEIR COOK NOTLEY COOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 9921 RICHLYN DR. PENNY HALL MD 21128 SISTER LOIS WELSH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-18-08 FROSTBURG, MD FROSTBURG MEM PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 60 W. MAIN ST., FROSTBURG, MD 21532 muers m00547 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lleri hD Feb. 15, 2008 D0017565 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) LIUSIE MD ZITUL 912 Netil Huy JBO Ilino 31. Date filed (Month, Day, Year) §32. Registrar's Signature FEB 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 6, 2008 1:07 P M Daniel Timney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Allegany Lonaconing Eale Nursing Home 8. Date of Birth (Month, Day, Year) May 6 1915 7. Age (In yrs. last birthday) 92 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 214-07-3853 1 X M 2 □ F Marvland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1XXXyes 2 □ No Allegany Barton MD. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21521 19022 Water St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WW 2 If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fiber Manufacturer Elementary/Secondary (0-12) College (1-4or 5+) Spinner unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hettie Warnick Timney John ပ 19a. Informant's Name/Relationship (Type. Print)
Alexa Fazenbkaer/ niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 128 Kalbaugh St., Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 20c. Location - City or Town, State 20a. Method of Disposition 02/07/ Cumberland Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 7 Win 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Yeaws /Medical Due to (or as a consequence of) Examiner Dron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed; 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical

within 24 hours after death To the Funeral Director: Hospital

filled in by the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certific

29d. Date signed (Month, Day, Year) 29c. License number

008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Dr. SL Sandhir, 48 Tarn Terrace, Frostburg, Maryland 21532

State Registrar

31. Date filed (Month, Day, Year)

2008 FFB



DONNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Nursing & Rehab C 8. Date of Birth (Month, Day, Year) May 30, 19 Sex 1 □ M 2 □ F **Funeral** Days Min. ŃΥ 055-20-1912 1926 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No WV Mineral Ridgeley Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26753 USA Rt. 4 Box 87 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 □ Xo Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marco Vitale Josephine (Rina) Vitale ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HC 86 Box 413A Fort Ashby WV 26719 Robert Toscano son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Ashby Cemetery 2/20/2008 WV Fort Ashby 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a Firth, Firter the disease, or short, or heart failure. List or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest is no one cause on each line. Approximate Interval Between Onset and Death Imme I te Cause (Final diseas or condition resulting in death) Advanced Endstage **Physician** month /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by

Saltimore, Maryland 21215-0036

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier worsorkshi

FEB 25

00055325

Feb 18, 2008

camberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP WONSOCK WALSH RD SHIN

31. Date filed (Month, Day, Year) State Registrar

32/Registrar's Signature 2008

the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Raymond Otis Trent, Jr. ZVDS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner en Bir mnne mi Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1**X** M 2□ F 84 217-18-3848 31,1923 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 21146 USA 14 Holly Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Dates: 1 ☐ Never Married 2 ☐ Married 1942-1946 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White 9 3 ₩ Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Administrative Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Irene Feast Raymond Otis Trent, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 508 West Drive Severna Park, MD 21146 Linda Hartlove/ Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. Glen Haven Memorial Glen Burnie, MD 2008 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Services 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ran **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence q Examiner the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 No Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To After this Division or 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

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Registrar

31. Date filed (Month

2008 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items of Maryland beplanten of Health and Mental Hyglene Amend Item 24a per verb., g877, 03/07/08dbb 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Emily C. Vecellio - 2005 /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl Examiner Che M. If Under 1 Year Months Days If Under 24 8. Date of Birth (Month, Day, Year) 04/15/1918 9. Birthplace (State or Foreign Country) Maryland Funeral Months 1 □ M 2 1 F 085-03-7377 89 Director Usual Residence of Decedent 10a. Sta. 10c. City, Town or Location 10d. Inside City Limits Anne Arundel r 28a-f show notified at show Gambrills 1 Yes 2 No Director Pennsylvania Centre State Colleg 10g. Citizen of What Country? 10e. Street and Number 730 Maryland Rt.#3 South To Code ns 23a or 'must be r 21054 United States Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or Items dical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943-45 Specify ģ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Stanton Emily Cecelia Applebee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen L. Jankowski/Daughter 1084 Saxton Drive, State College, PA 16801 Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 M Other (Specify) Entombment Resurrection Cemetery 02/09/2008 | Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fuger Service Licensee Mulle 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2□No 2X No 1∐ Yes To the Hospital or Attending Physiclan: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G8 // 3/10/08 III Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Washington Doris C February 2009 /Medical Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c v of Death Examiner PLata If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/19/1926 9. Birthplace Country) State or Foreign 52201 S28rity6434 **Funeral** Hours Days 1□M 2XF 81 Yrs Maryland Director -3504Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Charles LaPlata Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 USA 206 W Hawthorne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Black Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 nd Mental Hygiene. marked other than College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be ပ James N Campbell **Frances** Chesley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20613 19a. Informant's Name/Relationship (Type. Print) Health a 15225 Edgebrook Pl. Brandywine, Maryland ace of Disposition (Name of Date 20c. Location - City or Town, State William Washington/ Son permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 XBurial 2 □ Cremation 3 □ Removal from State Sacred Heart 2/12/08 LaPlata, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature 1 Feet ral S > c Licenses 22. Name and Address of Facility Adams Funeral Home PA nny in 191 20605 Aquasco Road Aquasco, Maryland 20608 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) creprovaon Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner requires that the death certificate be executed bunial-tran and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed certificate Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11855 Holly Lane Waldorf, md. 2060/

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

FEB 08

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 9:50 Α Willingham February 2008 Donna Jean /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 620 Souder Road, #104 Brunswick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 26, 1946 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 x F 61 Pennsylvania 212-50-9687 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1 XYes 2 ☐ No Director Brunswick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be United States 620 Souder Road, #104 21716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Wisor Robert Wayne Bumbarger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Concord Dr. Brunswick, MD 21716 Neal Wilhelm / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 2008 21. Signature of Europe Service License Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immedia Cause (That disease or condit in resulting in death)

Atherosclerotic Hypertensive Heart Disease

Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Hypercholestrolemia burial-trar Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☒ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 🗆 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 total Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate | 2□No 2XXNo 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendi hours after death. Ineral Director: A y filled in by the fi death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabiha M. Mohiuddin, M.D. 801 Toll House Ave., Suite B, Frederick, MD 21701 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 12 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **5** Month **Physician** P^{M} 2008 8:24 February Emily R. Warriner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton er 1 Year | If Under 24 Hrs. Days | Hours | Min. Cecil Union Hospital Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Maryland Director 209-14-4075 82 Jan. 21, 1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h County 10c. City, Town or Location 10d, Inside City Limits 28a-f sh notifled 1 X Yes 2 □ No Director Cecil E1kton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or is 23a / USA 1 Price Drive 21921 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status "natural", or item ledical Examiner r Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: à 3 Widowed 4 □ Divorced White Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service 11 Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 John Tereszcuk Pauline Mocryka 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau 559 Biddle Street, Chesapeake City, MD 21915 Peter J. Tereszcuk/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Rose of Lima Cem. 2/11/2008 Chesapeake City, MD 22. Name and Address of Facility
R. T. Foard Funeral Home, P.A. Signature of Funeral Service Licensee 318 George Street, Chesapeake City, MD 21915 uchard 23a. Part1 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Immediate Cause (Final disease or condition resulting in death) Physician unknown /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Chknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ■ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
S.S. Sachder MD 118 North SI Suit 3B, Elhten MO 21921.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

FEB 1 1 200B

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		·	1 - State of Maryland / Departm	nent of Health and f cate of Death		ene 008	05588
	Physici		1. Decedent's Name (First, Middle, Last) Robert James Wilson		2. Date of Death February	15 2008°	3. Time of Death 1:45 A M
	/Medic Examin			City, Town, or Location of Death Vesternport	1	4c. County of Death Allegany	
	Funeral Director			Under 1 Year If Under 24 Hrs. nths Days Hours Min.	8. Date of Birth (Month, Day, Y June 29	9. Birthe Cour. 1921 Mary.	lace (State or Foreign http) Land
	yland how		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD. Allegany Barton	n		1	0d. Inside City Limits
	r 28e-f s	Director	10e. Street and Number 10	of, Zip Code	100	g. Citizen of What Cour	XXYes 2 □ No ntry?
	eath wit	Funeral D	19105 South Eutaw St. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21521 Decedent of Hispanic Origin? (S		nited State	
5-0036	ours after d rel', or Item Examence	þ	1 Never Married 2 Ty-Married 1 Ty Yes 2 No W/W 2	Decedent of Hispanic Origin? (St., specify Cuban, Mexican, Puert of State of State of Specify:	o Rican, etc.)	Black, White, Specify: Whi	etc.
21215-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "neturel", or items 23e or 28e-f show eumetic event, the Medical Exura activities to infilied at	Completed	(Specify only highest grade completed) (Give kind of life. DO No	s Usual Occupation of work done during most of wor IOT use retired) Mist	rking	sb. Kind of Business/In Paper Manuf	_
and 2	m = 0 €	Be	17. Father's Name (First, Middle, Last) Ralph S. Wilson	18. Mother's Nar Flore	ne (First, Middle, Ma nce Hard		
Maryland	nd 2 should be fall hand Mental I	To		Idress (Street and Number or Ru Thompson Road	ıral Route Number, (City or Town, State, Zip	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic en		20a. Method of Disposition 1XI Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	(Name of y or other place) em. Garden 20		oc. Location - City or To umberland M	
Balti	permit. DepartmImporte any inju			me and Address of Facility Bo Church St., W			d 21562
Priysicia /Medica Examine pue pue		Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	a mode of dying, such as cardiac			Approximate Interval Between Onset and Death
s, P.O. Box 68760,	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the b	by Physician/Medical		opic pregnancy er (specify) ying cause given in Part I.	23e. Did toba	23d. Date of deliv Month	Day Year
Records	law requas been 2 should	Completed b	(a plan som disease		24a. Was an autopsy performe	24b. Were auto	opsy findings available mpletion of cause of
Vital	icien: 'certifica	Be	25. Was case referred to medical examiner? Hospital: 4 Classical of SERIO and the series of SERIO and SERIO	Othor	ath (Check only one,)	
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification; To	27. Manner of Death Accident Second not be Second not be	28c. Injury at Work?	28d. Describe how	eet and Number or Run	
2	spitel or /		29a. Certifier Physician: To the best of my knowledge, death occi	urred at the time, date and place	City or Town,	use(s) and manner as s	stated.
	thin 24 I	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
	F 3 F 8		· Sen	021244		2/15/20	08
	AV	3	30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Dr. Jesus Tan, 4 Broadway, Frostburg, 1		2		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 5 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:32 PM Donald Llovd Wildman February 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Moran Manor Nursing Home Westernport 8. Date of Birth (Month, Day, Ye May 23, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1**X**3M 2 □ F 236-62-0909 73 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TYes 25 No WV. Mineral Kevser 10f. Zip Code **26726** 10g. Citizen of What Country? 10e. Street and Number 200 Pinepointe Drive Apt. 2 A United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? **EXES 2 Norean Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2CXNo Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paper Manufacturer Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lloyd Delmas Wildman Agnes Josephine Sullivan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Wildman/ brother Rt. 1, Box 212 B, Burlington, West Virginia 26710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State Cumberland Crematory Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses Wagne 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Coronam 2 100 Yes

Physician /Medical **Examiner**

certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic access.

burial-trar attending physician the as use for the detached certificate

After

filled in by the

 Hospital or Attendl
 Hours after death.
 Funeral Director: A death.

To the Hospital within 24 hours a To the Funeral C

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

25. Was case referred to dical examiner? Other:

26. Place of Death Check onl one 4 varsing Home 5 ☐ Residence 6 ☐ Other (Specify)

21 No 1 🔲 Yes 27. Manner of Death

3 ☐ Suicide

+ Matural 2 Accident

5 ☐ Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland

State Registrar 31. Date filed (Month, Day, Year)

2008 8 FEB



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 ams **Physician** e anne 3 2008 /Medical 4c. County of Deaty 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, #1506 Examiner Silver OakLeaf Ds. mont SOSMERC 11215 24 Hrs. If Under 1 Year | If Under 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. 1□M 2**K** F Months Days Hours May 4, 220-42-1702 1943 Washington, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 K No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11215 Oak Leaf Drive, #1506 20904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 Tyes 2 KNo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Preschool 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Charles Williams †reva Leola Cameron 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Rowley/Sister Quimby Avenue, Beltsville, MD 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 1 ☐ Burial 2 【XCremation 3 ☐Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signeture of Funeral Service L 22 Name and Address of Facility. Francis J. Collins Funeral Home Inc. Silver Spring. 500 University Blvd, W. MD 20901 olications that caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final **Physician** 1Gr 5895Y disease or condition resulting in death) 18009 0 Carviovascu /Medical Du to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 2Z Vital 1∐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fun

completely 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of contifier momE

State Registrar 31. Date filed (Month, Day, Year)

FEB

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (0) BRECKER, MO DME Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

	1	For State			and / Depar <i>Certi</i>	ificate o						eg. No.	200	3. Tir	me of Death
Physicia cal Examir	er	. Decedent's Name (First, Midd			HUMBERT	O REQU					Month February	Day 12, 20	Year 008 . County of Dea		555 hrs
	4	la. Facility Name (if not institution Washington County F			ımber)			Town, or Lerstown				V	Vashington		
Funeral irector		5. Social Security Number	6. Sex	2 F	7. Age (In yrs. las	t birthday)	Mont	hs Days	If Under Hours				DD/YYYY) 9. B Fore	ian	
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1715-0036 Idee filed within 72 hours after death with the Maryland Actael Hygene. anticed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	~ _	Maryland 10e. Street and Number 10 EAST BALTI	MORE.	STREE	<u></u> -			p Code 2	1740			-	zen of What Co duras	ountry?	
with the us 23a o		11. Marital Status			cedent Ever in U.S	6. 13. V	/as Deced	lent of Hisp cify Cuban,	oanic Origi Mexican,	n? (Spe Puerto R	cify Yes or Ni cican, etc.))-	14. Race - Am White, etc.		ndian, Black,
er death	Funeral		Married vorced	1 Yes Yes, Give Ye	2 X No						lurian		Specify: His	pan	ic
natural'	Completed by	15. Decedent's Education (Sp	ecify only	highest gra	ide completed)	16a. Deced	ent's Usua	I Occupati orking life.	on (Give k	ind of wo	rk done		Kind of Busines		
36 hin 72 h e. than "r edical E	nplet	Elementary/Secondary (0-12)	12th	(1-4 or 5+)	Co	nstr	ıctio					onstruc	tio	n,Co.
21215-0036 und be filed within 72 hours after Mental Hygiene. marked other than "natural", it event, the Medical Examiner	e Con	17. Father's Name (First, Middl	e, Last)	CARLOS	S H. REQU	JENO					First, Middle, LTAGRA		BENITE	Z	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relation Wilfredo Beni	ship (Typ	oe, Print)	other)	19b. Mail	ing Addre	ss (Stree	t and Num 非 202	ber or Ru	ural Route Nu Lver S	mber, C	City or Town, Stang, MD 2	ate, Zip 2091	Code)
e, MD I and 2 sho Health and Item 27 is	}	20a. Method of Disposition			20b. F	Place of Disp rematory or	other place	e)	l l		Date		Location - City		
Baltimore, permit. Pages I at Department of He. Important: If ite		1 X Burial 2 Crematic	Specify:		Ceme	etery	Mcpa.	l Int			/27/08		ın Juan		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		21. Signature of Funeral Service	Va C	Ha	her to				_				inerales		
Physician		23a. Part I. Enter the disease, failure. List only one caus	e on eac	h line.		Do not ente	r the mod	e of dying,	such as ca	ardiac or	respiratory a	rrest, sh	nock, or neart		pproximate In Between Onse Death
Examiner	Ī	Immediate Cause (Final diseas or condition resulting in death)			njuries a consequence of	f):								\top	
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Box 68760, e death certificate be the attending physic ed for use as the bur	cian/I	23b. Was decedent pregnant in past 12 months?	the		e birth gnant at time of de	2 eath 5	Fetal dea Other (S		Ectopi	c pregna	ncy		Month	Бау	100
Box he death the atte	hysi	1 Yes 2 No 9 1	Inknown	1	nown to death but not n	esulting in th	ne underly	ing cause	given in Pa	art I.	23e. Die	tobacc	o use contribut	e to the	cause of deat
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Divi	Certification:	4 Homicide	ould not l etermined	Speci	ify) Home								more, ST		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) Certifying Medical E	Physici xaminer	:On the bas	best of my knowled	dge, death o and/or inves	ccurred at tigation, ir	the time, on my opinion	date and p on, death o	lace, and occurred	I due to the c at the time, d	ause(s) ate and	and manner as place, and due	to the c	ause(s)
Vithi Totl	Medical	29b. Signature and title of cer		and manne	er stated.			29c. Licer	se numbe			29	d. Date signed	(Month	, Day, Year)
Dille			11	N.	16/5	12		0.0	.M.E.				ebruary 13,	2008	
		30. Name and address of pe Laron Locke MD.	on who	completed c tant Medi	ause of death (Iter ical Examiner	n 23a) 111 Po	enn Stre	et, Balt	imore, N	MD 212	201				
	tate	21 B 1 61 1 64 1 1 B 1 1	2 20	32	Registrar's Signa	ture	ano de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 4 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year THERESA MARY BRADLEY **Physician** 24,2008 4:00P FEBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RASPEBURG BALTIMORE 432 OLD HOME ROAD 8. Date of Birth 10-17-1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 213-20-5793 82 1 M 3 F Yrs MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE RASPEBURG MD the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with : feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or ? 21206 U.S.A. 432 OLD HOME ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BURKHARDT J. REBBERT MARGARET (RADEJ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSEMARY BRANDT/DAUGHTER 432 OLD HOME ROAD BALTIMORE, MD 21206 Health Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY 2-27-08 TIMONIUM, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MISE STRUCTIVE **Physician** /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and is the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an cate has autopsy nerformed 1□ Yes 2□ No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

ASNEEM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per dr., g876, 192425 1984 hbh 05594 1 - State Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month /Medical X 4a. Facility Name (If not institution, 4c. County of Death Examiner CARROLL 4-STM If Under 1 Year 8. Date of Birth (Month, Day, Feb 20, 5. Social Security Number Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days ^{Year)} 1956 12 M 2 □ F Country)
Maryland 220-48-3323 Director 51 Feb Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 28a-f show MD Director Carrol1 WEstminster 1 ☐ Yes 2√7 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 2 ry or other traumatic event, the Medical Examiner must be not so or other traumatic event, the Medical Examiner must be not or other traumatic. 2551 Stone Road by Funeral 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 engineer high rise bldgs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Barnhardt 2 Eleanor Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Barnhardt/spouse 2551 Stone Road Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Stryice Licensee KOn 3 d S Waste State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Appendiceal Immediate ause (Final disease or condition resulting in death) **Physician** cancer 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) has pick ٥ 1 ☐ Yes 2**V)**No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of D ath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 5 Pending investigation 1 X Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) FEB 2 5 2008

DHMH 17 Rev 1/2001

Place

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

32. Registrar's Signature

Paul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00 P M February 24, 2008 Elsie May Borman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center For Hospice Towson 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/09/1916 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🖾 F 218-32-9312 91 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show at 1 ☐ Yes 2 XXIII be notified Directo Maryland Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ò U.S.A. 21286 500 Virginia Avenue, Apt. 1201 or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: White Completed by 3 ☐ Widowed ♣ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Sewing Factory 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Mitchell George W. Crofoot ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Department of Health a Important: If Item 27 is any Injury or other tra 546 Country Ridge Circle, Bel Air, Maryland 21015 Debbie Bender (Granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 Cremation 3 Removal from State 02/28/2008 Baltimore, Maryland Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fullynski Funeral home, P.A. 21. Signature of Furieral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease of condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signification of the category of Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy nerforme 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ !npatient Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. 6701 Monc 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Doris Bostick 0911 20 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner more If Under 24 Hrs. amaritan Hospi 8. Date of Birth (Month, Day, Year) 11-9-1923 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2√ F S.C. 84 Director 245-28-6082 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1508 N. Caroline Street 21213 U S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite Never Married 2 Married 3 Widowed 4 Divorced Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School System 10th grade Pastry Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Bostick Mary Timmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Oscar Vines-Godson MD 21213 1516 N. Caroline Street Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of I Important: If Ite any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Pk 2-26-08 Randallstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signatur 22. Name and Address of Facility March F/H East of Funeral Service Licenses North Avenue Balto, MD 21202 1101 Ε. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Partl. Enter the disease shock, or heart lature. Immediate Cause (Final **Physician** m ocord disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) been signed by the s a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 🗌 No 3 Probably 4 Unknown Di 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐2R/Outpatient 3☐ DOA 1 🔲 Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation atural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6500H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard 21239 Taven leresa 5601 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05597 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3:30 P M EvaJean Elizabeth Berg February 21, /Medical 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 116 Woodwind Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 💢 F Director 69 213-36-8554 Sept.20,1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 116 Woodwind Road 21228 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) Theater Actress marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injuy or other traumatic event once. Be Jeannette Hazel Lindemore Llewellyn Ward Kellam 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph Berg, Jr. Husband 116 Woodwind Road; Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem.Garden 2/25/2008 Marriottsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Falleral S 10,290 1630 Edmondson Avenue; Catonsville MD 21228 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): 45 month **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 🏖 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 ome 5 Residence 6 □Other (Specify)
28d. Describe how injury occurred ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: After 1- ■ Natural 2 □ Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

107

State Registrar 31. Date filed (Morth, Day, Year) 32. Registrar's Signal FEB 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FNONTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 21, 2008 HARRY F. BLEAKLEY, JR. 3:20 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE STELLA MARIS NURSING HOME TIMONIUM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **X**□M 2□F 86 Director 213-16-3562 12/8/1921 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 ☐ XNo be notified Director GLEN ARM BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number ō USA 21057 4215 MANORVIEW ROAD must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items other traumatic event, the Medical Examiner 72 hours after XXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE COUNTY POLICE OFFICER 12TH GRADE Department of Health and Mental Hygic Important: If Item 27 Is marked other I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNA MARIE RESCH HARRY F. BLEAKLEY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9100 OLD HARFORD RD. PARKVILLE, MD Important: If Item 27 any Injury or other tr. SHERRY HOFFEN/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 3/7/2008 PARKWOOD CEMETERY BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JOHNSON FUNERAL HOME 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the l IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) sbeen signed by the should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 After this certificate has autopsy 2 Z No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specity) 2 No 1 Tes Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22, 2008

DHMH 17 Rev 1/2001

State Registrar

5+1

EBRUARY

HARRY

BLEAKLEY,

2300 DULANEY VALLEY ROAD

21093

TIMONIUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CORAZON SOARES, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛛 🗎 🦰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Anna Mae Bierman 2008 21:45 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel If Under 1 Air, Maryland Harford Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2**X** F Director 80 216-20-8432 06/09/1927 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 No Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2926 Toddsbury Court U.S.A. 14. Race - American Indian, 21009 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3 | 1 9 | 0 8 31 1 5 5 93€ Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvi Samuel Koski Alma Daisy Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2926 Toddsbury Court - Abingdon, Maryland 2 of Disposition (Name of Date 20c. Location - City or Town, State Denise A. Polek (daughter) 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns.02/25/2008 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assahn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FIBROSIS ULMONARY 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Bivision of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No ۴ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1. A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) FEB 2 5 32. Patrar's Signature Registrar

State Registrar

DHMH 17 Rev 1/2001

9000 Franklin Square

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R Mada Chavaon—Borne 9000

gistrar's Signature

1. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH.g877, 3/3/08 TT Certificate of Death Reg. No. ZUUS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY Day ⊇121... 2008 Nina Bell Brvant 5:53P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Joseph Medical Towson Center 8. Date of Birth (Month, Day, Year) 6. 1936 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 54-1178 6 Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Hours Director North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 □Yes 2XNo Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Weston Court 21093 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 X No White Specify. Specify: 3 ☐ Widowed 4 🔀 Divorced Completed and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Earl Sellers Onie Clemmons or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Kim Evans (daughter) 6 Dunwich Road, Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Svc. Corp. 02/25/2008 Towson, Maryland 21. Sign to re of neral Serice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS disease or condition resulting in death) CORDNARY ARTERY DISEASE Due to (or as a consequence of): **30MINUTE** CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of siclan and burial-transit as use ō ed by the a æ has

Physician /Medical Examiner certificate be executed

the Manyland

with

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Physician:

To the Hospital or Attending

29b. Signature and title of certifier

address of person who completed cause of death (Item 23a) (Type, Print)

2

GUNNINGHEM M.D.
32. Registrar's Signature

within 24 hours after usa...

To the Funeral Director: After this

5	
Sta	
Registr	ar

dical Exam	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al déath 3 ⊟Ectopic			23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2₭ No 3☐ Probably 4 ☐Unknown
Completed					24a. Was an autopsy performed? 1∐ Yes 2 💆	
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
ation:	27. Manner of Death 1 ↑ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
Medical (29a. Certifier (Check only one) 1X Certifying Phy 2 Medical Exami	rsician: To the best of my know iner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
š	29h Signature and title of certifier		2	9c. License number	204 [Anto signed (Month Day Year)

29c. License number

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29d. Date signed (Month, Day, Year)

2008

MARYLAND 21204

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Robert Charles Burrows 19, Feb. 10:25 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours M 2□ F 78 1/16/1930 154-20-7585 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR406 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Airline Ind. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest C. Burrows Bernita Fox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / Wife 719 Maiden Choice Lane, HR406, Catonsville, MD Lerlyne N. Burrows 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2/25/2008 | Crownsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Ent. I dealing to Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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"natural", or items 23a or 28a-f sl edical Examiner must be notified

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permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of

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Important: I any Injury o

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

/Medical

or Attending Physician: The law requires that the death certificate be executed the burial-transit and attending physician use as the by pe director, page 2 should certificate has

Division or Vital Records, P.O. Box 68760,

After this death. hours after death uneral Director: filled in by the Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Nursing Home 1 | Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injun √ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29c. License number

29d. Date signed (Month), Day, Year

within 24 hours a

State Registrar 31. Date filed (Month, Day, Year) FEB 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrar Certificate of Death Reg. No. 2008 05603
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 148 pm 3. Time of Death Month Day Year 2008
	Examin		4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Qountry) Months Days Hours Min. (Month, Day, Year) If Qountry)
L	Director		127-28-4874 1 M 2 PF 9/1 Yrs. Months Days Hours Min. 4-19-19/6 Manufand
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryl r-f sho fied a	tor	Md Montanmery Chevy Chase
	filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath w	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
9	after d or Iten miner		Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
000	hours tural;	d by	3 □ Widowed 4 IZ Broorced Year or Dates:
75	nin 72 t. In "nat Medici	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry
2	ed with	Com	12 6 Professor Nursing
Maryland 21215-0036	ould be fill Mental H arked oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ary	should ind Mer marke	ဠ	John (Uliver Lancaster Seatrice Swan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Dr. Hariett Karuhije 4701 Willard Ave Chevy Chase, Ud. 20815
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Crty or Town, State
ij	permit. Pag Department Important: I any injury c		4 Donation 5 Other (Specify) Lincoln Mem Carl Feb 27 2008 Sur Tand Mil. 21. Signardle of Funeral Service License (22. Name and Address of Macility Lincoln Mem Carl And Mem Ca
ä	permit. Departr Importa any inji		Coulden C. Landay 1701 4c Cullah St. Balto. Md. 21217
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Coronary artery disease
	Examiner		Due to (or as a consequence of):
7	po #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying
_	xecute al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical	d
x 68	ertifica ling ph e as th	Medi	IF FEMALE:
Box	death certifica attending ph for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1
Р. О.	t the d by the ached	hysi	9 □ Unknown 9 □ Unknown
	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	v requi	eted	hypertensive cardiovascular 1 yes 20 No 3 Probably 4 Unknown
	The law e has l	Completed by	24a. Was an autopsy performed?
Vita	ding Physician: The lav n. After this certificate has funeral director, page 23	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
	Physic this ce al dire	ို	1 ☐ Yes 2 No
OU	nding I th. : After s funer	tion:	27. Manner of Death 1 S Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 28d. Describe how injury occurred 1 Types 2 No
Division or	after death.	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
5	oital or urs aftr eral Di		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th To th comp	Me	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
)	1		Jan 40 19 020297 2/21/08
(8		James H. Brodsky, mid 4701 Willard Are. Chery Chase Ind. 31. Date filed (Month, Day, Year) FEB 2 5 2008 32. Registrar's Signature FEB 2 5 2008
	Sta	te	31. Date filed (Month, Day, Year) FEB 2 5 2008 32. Registrar's Signature
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2008 05604

	Jul 40 0		- For State Certificate of Dec	ath	Reg	No.	
₽ł	nysicia		egistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 0258 hrs
rdical I		ner	Murriel Ricardo C	hew Jr.	Month E February 18	3, 2008	
			4a. Facility Name (if not institution, give street and number) 4b. Cit	y, Town, or Location of Death Itimore		4c. County of Death	
			Offiversity of Ivial yland Shock Traditio		8 Date of Birth	(MM/DD/YYYY) 9. Bir	holace (State or
	neral		5. Social Security Number 16. Sex	Inder 1 Year If Under 24Hrs onths Days Hours Min	. 1	Foreig	n
Dir	ector	1	217-15-3714 1XM 2 F 20 Yrs.		05 08	87 6	untry) MD
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land	f sho	ō	Los	Zip Code	100	. Citizen of What Cou	ntry?
Mary	d at	Director	Toe. Street and Number			U.S.A	
h the	23a or 28a-f show any notified at once,		2104 Woodbourne Ave	21244 redent of Hispanic Origin? (S	necify Yes or No-		ican Indian, Black,
hours after death with the Maryland	t be r	Funeral	1V Never Married 2 Married Armed Forces? If Yes, sp	pecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
r deat	or it	ᇍ	1 Yes 2X No	2X No specify:		Specify:	Black
's afte	niner,	2	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us	sual Occupation (Give kind of		16b. Kind of Business/	
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215-0036 be filed within 7	Mental Hygier marked other c event, the M	e	Murriel R. Chew Sr.		ly Isaa		
2 g	and Mental Hygiene. 7 is marked other th	흔	19a. Informant's Name/Relationship (Type, Print) Kimberly Dallas-Mother 19b. Mailing Add 2104 W	ress (Street and Number or	Rural Route Num	ber, City or Town, Stat ltimore,	Md 21244
MD d 2 sh	Health and Nitem 27 is nr traumatic				Date	20c. Location - City o	
. an an	f Hea f iter er tra	T	crematory or other pl	lace)		- 111	M.3
m O	ant:		4 Donation 5 Other Specify: King Memor	ial Park 2/	26/08	Randalls	stown, Md
Baltimore, permit. Pages 1 ar	Department of Health a Important: If item 27 injury or other traum:		i nature of Funeral Service Licensee	and Address of Facility Ch F/H West			01075
	Ğ <u>E</u> .E		23a. P/rt I. Enter the disease, or complications that callsed the death. Do not enter the mo	Wabash Ave	or respiratory arre	more, Mo est, shock, or heart	21215 Approximate Interval
	sician edical	1	# ilure. List only one cause on each line.	odo o. dyg, com co on co			Between Onset and Death
	miner	1	Imprediate Cause (Final disease condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):				1
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ord	as bee	<u></u> 등			autor perfo	osy prior to rmed? death'	
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of Vital Records,	certificate ector, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Cher		Residence 6 Ott	ner:
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of	After	<u>ۃ</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Month, 2803 (ear) 1 Natural 5 Pending Feb 18, 2803 (ear) 0231 hrs	1 Yes 2 V No	Subject sho		
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Division	after of Direct of In by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	actory, office building, etc.	or Town	State) f Russell Street, Ba	
	24 hours after Funeral Dire	is	4 V Homicide	at the time date and place a			
Division of Vital Records, P.O. Box 687	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	<u>8</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation,	in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
Ę	withi To the	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (i	Month, Day, Year)
		2	Our FT -	O.C.M.E.		February 18, 2	008
		1	July and some of some of death (from 23a)				
L	1	1	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 212	201		
	1	Hode	200 Paristantia Signatura				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year ELIZABETH FEBRUARY ZO ZOO /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GALTIMORE SOHING HOPKING BATVIEW MEDICAL CENTER Social Security Number If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 2√□ F Yrs. Director 229-38-5859 22 1934 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s consorted injury or other traumatic event, the Marie 1 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5949 St Regis Road USA by Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced al Hygiene.
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"It, the Medical Ev Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Homes 5th grade N/ADomestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Robert Broady Rosa Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin Carter - Son 5949 St Regis Road Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 2-25-2008 Randallstown, 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H East 21202 Ε. North Avenue Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any factories to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ဥ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 🖫 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar STERM

M.N. 4940 E

32. Registrar's Signature

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BROWN

MANDOUPH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. (_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4:40 P M February 16, 2008 Ethel R. Cadogan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Citizen's Nursing Home Frederick If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕅 F 1916 New York **Director** 071-10-6188 Feb. Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

Hygiene "natural", or items 23a or 28a-f show oher than "natural", or items 23a or 28a-f show oent, the Medikal Examiner must be notified at went, the Medikal Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No New Market Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21774 United States 5638 Morning Glory Trail Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married
Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (9-12) College (1-4or 5+) Dietary Cook Healthcare permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other tt any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Nelson Frland Erickson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5638 Morning Glory Trail, New Market, MD 21774 David Cadogan - Son 20b. Place of Disposition (Name of Meart own Prints or other place) 20a. Method of Disposition

A Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 4 ☐ Ronation 5 ☐ Other (Specify) Memorial Park 2-20-2008 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final 10 THRIVE FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BNEUMONIA Sequentially list conditions, if any leading time deficiency cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes À☑ No 24a. Was an has autopsy 2 No 1☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Hospital: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 TYes 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Little of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave theneruck, MD 2170 814 TOW IBTE KAZMI, HO 32. Gistrar's Signature 31. Date filed (Month, Day, Year) State FEB25 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 26 per doc 8876 2-25-08 vt. State of Maryland 7 Department of Health and Mental Hygiene 05607 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Loretta Margaret Carter 02 1:31 PM^M 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3825 Challedon Road Harford Jarrettsville 8. Date of Birth (Month, Day, Year) 09/05/1915 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🕱 F Hours May land **Director** 92 218-68-1849 Usual Residence of Decedent 10a. State 10c. City, Town or Location fshow 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.
14. Race - American Indian, Funeral 701 Ithica Court 21047 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph John Snyder Margaret Elizabeth Zimmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 Is m any injury or other traum once. Leslie J. Carter (son) 701 Ithica Court - Fallston, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Church Cem. 02/25/2008 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assaln 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myccardial /Medical Due to (or as a cons uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Canepr Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one daughter's 1 Tes 2 No Other: 4 Nursing Home 3 Schesidence Other (Sp 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Noc shail Ad ncchy M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records. P.O. Box 68760.

Saltimore, Maryland 21215-0036

within 24 To the F State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certif

ROBERT DUNCAN



Registrar

29c. License number

28136

29d. Date signed (Month, Day, Year)

21014

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Sloane

a Mr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Calvert St.

32 egistrar's Signature

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29c. License number

D41593

Site Wo Baltimore, MD 21218

maryland

29d. Date signed (Month, Day, Year)

			For State of Ma State Registrar		artment of Ho rtificate of D	ealth and Ment <i>Death</i>	al Hygiene Reg. No	2000	05610
			Registrar Decedent's Name (First, Middle, Last)			2. D	ate of Death		3. Time of Death
	Physicia /Medic	_	FENG YAN	CHAN	67	F	onth 20	2008	9:23/P M
	Examin	-	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		40	c. County of Death Howard	
			Howard County General Hosp 5. Social Security Number 6. Sex 7. Age	1 ta I e (In yrs. last birthday)	Columb If Under 1 Year	If I Inder 24 Hrs 9 D	ate of Birth		place (State or Foreign intry)
	Funeral Director		459-65-4178 1□M 2♥F	92 Yrs.	Months Days	Hours Min. (A	Month, Day, Year	16 Ch	intry) i na
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla -f sho ied at	to	Maryland Howard	Elkri	dae				1 □Yes 2 XNo
	r 28a	irec	10e. Street and Number	2787	10f. Zip Code		10g. C	itizen of What Cou	intry?
	th wit	ral D	8048 Hillrise Court		21075			U.S.A.	1 1 1
	er dea	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of His If Yes, specify Cuba	spanic Origin? (Specify) n, Mexican, Puerto Rican	Yes or No- 1, etc.)	14. Race - Ameri Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ M If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Ch	inese
2-00	72 hou natura lical E	sted	15. Decedent's Education (Specify only highest grade completed)	l (Give	dent's Usual Occupa	lurina most of working	16b. i	Kind of Business/li	ndustry
21215-0036	within 72 hours after death with the Maryland tene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)	DO NOT use retired, omemaker)		Own Home	
	filed within Hygiene. other than ent, the Me	ပ္ပ	17. Father's Name (First, Middle, Last)		Omemaker	18. Mother's Name (First			
an	lid be lental ked c ic eve	To Be	Ching-Chuan Tan	g		Hua	a Chen		
Maryland	and N is mar		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a	and Number or Rural Roo			
	and 2 lealth m 27 i		Yung-Nien Chang Son	8048 20b. Place of Dispe	Hillrise	Court Ell		Maryland Location - City or 1	
Jore	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other plac			•	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ftems 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) 21. Signalure of Puneral Service Licensee		2. Name and Addres				Home, Inc.
ñ	permil Depar Impor any ir		toul tagan		1050 York	Road Tows	son, Mar	yland 2	1204
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one called on each in			g, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		reculting in death)	UnoNI	A				
	Examiner		Due to (or as	a consequence of):	MAR	77			
		ner	Sequentially list conditions, Cause. Enter Underlying	a consequence f):	1/2 1	Tan	1. 0		
H	ecutec and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a consequence of):	Head	7 / 6116	coe		
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687		edical	a						
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.O.	0 0	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t time of death 5	Other (specify)				
Δ.	requires that the de een signed by the a nould be detached i	y Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
rds	w requires been sign should be						1 ☐ Yes	2 No 3 Pr	obably 4 ☐Unkn own
9 0 0	law as b 2 st	Completed					24a. Was an autopsy	prior to o	utopsy findings available completion of cause of
H	Th ate pag	Com					performed? 1☐ Yes 2☐	death? No 1 ☐ Yes	2 No
Vita	Physician; Th this certificate al director, pag	B	25. Was case referred to medical examiner?	Ent. OF FRIOutpotic	ent 3 DOA Oth	26. Place of Death (Cher: 4☐ Nursing Home		e Dother (Cae	off d
o		. To	27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatie			Describe how in		сну)
ion	Attending Prdeath. ector: After	atior	1 ☐Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation		M 1 🗆	Yes 2 □ No			
Division or Vital Records,	or Atte ter de: lirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inj building, e	ury - At home, farm, s tc. (Specify)	treet, factory, office	28f. 1	Location (Street City or Town, Sta	and Number or Ru ate)	ural Route Number,
	pltai o		29a. Certifier 1- Certifying Physician: To the best	of my knowledge, dea	ath occurred at the tir	me, date and place, and	due to the cause	e(s) and manner as	s stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) Medical Examiner: On the basis of and manner st	of examination and/or i	investigation, in my o	opinion, death occurred a	at the time, date a	and place, and due	e to the cause(s)
	Vithii Vithii To th	ž	29b. Signature and title of certifier My Khells Me S		29c. Licens	e number	29d. I	Date signed (Mont	th, Day, Year)
	V.		In hour	looth (Itam 20=) (T	Print) V=	10/	18 554	as .	coof
	2		30. Name and address of person who completed cause of 200 ACu US 4 AC, 52	17 35 (Type	BATT	MORE	un)	2/201	6
		ate	31. Date filed (Month, Day, Year) FEB 2 5 2008	rar's Signature					
П	Regist	rar	FEB % 5 ZUU8	and the same of th					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 20, 2008 Physician Carter February Κ. Rosamond /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center Towson Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 XF Maryland April 10,1929 Director 212-28-3045 78 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director Timonium Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 2525 Pot Spring Road, Apt. K-306 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic aver Hilgenberg Pauline Charles Frederick Kraus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Owings Mills, Maryland 21117 126 Gwynnbrook Avenue <u>John W. Carter</u> 20b. Place of Disposition (Name of cemetery, crematory of other place) Dulaney Valley Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-25-2008 Timonium Maryland 4□Donation 5X1Other (SpecifyEntombment 21. Signature of Remeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. emo disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 PYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes Medical Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2:45 P M

1 ☐ Yes 2XXVo

Approximate Interval Between Onset and Death

ears

Year

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d Date signed (Month, Day, Year)

February 21, 2008

funeral director, After Director: filled in by the n 24 hours af ne Funeral I completely To the I within 2

> State Registrar

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

5 ☐ Pending investigation

6 ☐ Could not be

determined

0

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DWSON DWD

Injury

28c. Injury at Work?

Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	For State Registrar	State of M	aryland / Do	epartment o Certificate		nd Menta	al Hygier Reg. N		8 056
Physician /Medical	1. Decedent's Name (First, Middle,						B Zu		r 1355 F
Examiner	4a. Facility Name (If not institution, NNIVERS I TO OF A	IARYLAND ME	ELICAL LEX	TER K	2.1-1	RE		4c. County of D	N/A Birthplace (State or Ford
uneral irector	5. Social Security Number 218-26-3913	6. Sex 7. Ag	ge (In yrs. last birth	day) If Under 1	Year If Under 2 Days Hours	Min. 8. Da	onth, Day, Yea	ar)	Country) Maryland
show od at	Usual Residence of Decedent 10a. State 10b. County	Baltimore	10c. City, Town	or Location	Baltimor	e			10d. Inside City Lin 1 □¥es 2 □
or 28a-f be notifie Directo	Maryland 10e. Street and Number			10f. Zip Co	ode 21 2	728	10g.	Citizen of What	t Country?
Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Nawidowed 4 ☐ Divorced	12. Was Decedent Armed Forces	; % 0	13. Was Deceder If Yes, specify	nt of Hispanic On Cuban, Mexican			Black, V Specify:	American Indian, White, etc.
t, the Medical E	15. Decedent (Specify only highes Elementary/Secondary (0-12)			Decedent's Usual ((Give kind of work life. DO NOT use	done during mos retired) Homemak	er			ess/Industry)wn Home
c event, t	17. Father's Name (First, Middle,	ah Dempsey			18. Mothe	er's Name (Firs		den Surname) Dempse	у
7 is market traumatic TO	19a. Informant's Name/Relations		19b.	Mailing Address (5	Street and Number				
t: if item 27 y or other i	Deartriss Holland 20a. Method of Disposition 1 Daurial 2 Cremation 4 Donation 5 Other (S		e cemeter	Disposition (Name y, crematory or oth	of erplace)	Date		. Location - Cit	y or Town, State klyn Park, Md.
importan any injur once.	21. Signature of Funeral Service		Tenst	22. Name and	Address of Facili	ty rs Funeral Place Baltii	Service, P). A. 21217	Approximate
physician and medical learning the burial-transit music learning the burial-transit medical Examiner		a. Due to (or a Due to (or a C.	A MONIA as a consequence of as a consequence of as a consequence of	FIBROSI	ک				Onset and Deat
d by the attending phy letached for use as the letached for use as the Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe				23d. Date of Month	h Day Yea
be d	à la	1 ☐ Yes						acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 □Unkno	
2 2 2							24a. Was an autopsy performe 1☐ Yes 2	pri	ere autopsy findings ava ior to completion of caus ath? Yes 2 No
is certific director,	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1-1 Inpa	atient 2 ☐ ER/Ou	utpatient 3 DO	A Other: 4 🗆 N		5 Residen	ce 6 Other	
Mymn 24 nouts arec useau. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Modical Certification: To Be Com	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation not be 28e. Place of		М	8c. Injury at Work? 1 ☐ Yes 2 [, office	□No	Location (Stre	escribe how injury occurred cation (Street and Number or Rural Route Number, by or Town, State)	
Funeral Director: etely filled in by the		ng Physician: To the be I Examiner: On the basi	s of examination a	e, death occurred and/or investigation	at the time, date , in my opinion, d	and place, and eath occurred	due to the cau at the time, dat	use(s) and man te and place, ar	nner as stated. nd due to the cause(s)
complete	29a. Certifier (Check only one) 29b. Signature and title of tertifier (Priority one)	and manner	Mos Kori		License number				(Month, Day, Year)
1	30. Name of address of perso	n who completed cause of MoS Four 72		(Type, Print) 22 S- (122524 REENE	>- B	ALTIMO	RE MA	21201
State Registra	e 31. Date filed (Month, Day, Yea		istrar's Signature	Locali	9				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** FEB. 18, 2008 0147 ROSE A. DIFATTA /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (II not institution, give street and number) Examiner BALTIMORE GILCHRIST HOSPICE TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) MARYLAND Months Days 1 □ M **X**(X) F 215.01.8765 FEB. 7, 1917 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2000 No sa or 28a-f sh t be notified Director TOWSON BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5459 PRINCESS DR. 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 'natural', or iter dical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married or 1 ☐ Yes 2 ☒ X lo Baltimore, Maryland 21215-0036 Specify: ģ 3XXWidowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FOOD MEAT_PACKER of Health and Mental Hygie If Item 27 is marked other I or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPHINE STIPEK NORBERT SVEC ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any Injury or other tr once. 5459 PRINCESS DR., ROSEDALE, MD DAUGHTER DOLORES THOMAS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FEB. 19, 2008 BALTIMORE, MD. BAYVIEW CREMATORY INC. 21. Signature of Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. K. KREGORA FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. 23a. Part1 Enter the diseas shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Reac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leafing to it must be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death • Funeral Director:

Certification: To 5 Pending investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical and manner stated. within 24

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

February 18, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARile Balto md 2,20% GBMC 6701 N. Choules St.

State Registrar

31. Date filed (Month, Day, Year) FEB 2 5 2008 32. Registrar's Signature

10

		State of Maryla	nd / Depa	artment of H	ealth and M	fental Hy	giene 2 (008	05614
	-	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Jeath	2. Date of De	Reg. No.		3. Time of Death
Physicia		Walter M. Emala					ary ^{Day} 20,	2008	12:20 AM
/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		4c. County of			
		Stella Maris Hospice Center		Luthervi				imore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date (Months Days Hours Min. 06/1				8. Date of Bin (Month, Da	th y, Year)	Coun	
Director		Usual Residence of Decedent				06/14/1	1925	[Mary]	Lanu
ryland thow			city, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes ②
he Ma 18a-f s otified	Director		sex	10f. Zip Code			10g. Citizen o	f What Cour	
with t		10e. Street and Number 5 Brett Court, Apt. #10		2122	1		U.S.A	•	
death ms 20	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No		ace - Americ	
hours after death with the Maryland tural", or Items 23a or 28a-f show Examiner must be notified at		1XXNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1	1 ☐ Yes 🏋 No	Specify:	1 110411, 010.)		ack, White, Whit	
"natural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of		
hin 72 e. an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of work)	ing			
ed with ygiene ygiene that the	Сош	6	Clerg	У		45° 4 45° 1-11	Religi		
be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam Emma Gral		, Maiden Surna	ame)	
should nd Mer mark matic	욘	Walter J. Emala 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a			er, City or Tow	n, State, Zip	Code)
ind 2 satth ar 27 is sr trau		Blanche Salkowski (Sister)	902	Louis Lan	e, Kings	ville, l	Marylan	d 2108	37
es 1 a of He of He if item		200, Monod of Bioposition	cemetery, cre	osition (Name of matory or other plac	e) ¦	Date	20c. Location	,	
tment tant: tant: jury c		4 □ Donation 5 □ Other (Specify)		eart of M					Maryland
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		21. Signature of Funesal Service Licensee	2	2. Name and Addres Br 1407 Old	ůzdžinsk: Fastorn	i Funera	al Home Essex	P.A Marv	land 21221
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		23a. Part1. Example is usease, or complications that caused the de shock in heart failure. List only one cause on each line.						ricit y.	Approximate Interval Between
Physician		Immedia Cause (Final disease or condition LUNG CANCE	R						Onset and Death
/Medical Examiner		resulting in death) Due to (or as a conse	equence of):						
	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):		_				
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Lisease or Injury that initialed events							
cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a conse	equence of):						
physic physic the b	dical	d						-	
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregable.					23d. [Date of deliv	ery
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at the ded by the deserted	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not re	esulting in the L	inderlying cause give	en in Part I.	23e, Did	tobacco use co	ontribute to t	he cause of death?
w requires that is been signed to should be detailed.	d by	Fatti. Other significant conditions contributing to document for	Joanning III the C	andonying oddoo giri	or are a		Yes 2□ No		bably 4 XUnknown
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Physician: The lauthis certificate has all director, page 2	omp			11/1		auto perfi 1∐ Yes	ormed? 2 X No	death?	mpletion of cause of 2 ☐ No
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dling I h. After funer	tion	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation		Worl	k? Yes 2 □ No	ZQQ. DOGGINDG	non ngary ood		
Atten ar deat ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, st	treet, factory, office			(Street and Number, State)	mber or Run	al Route Number,
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o the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 2□ Medical Examiner: On the basis of exam and manner stated.							
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Mec	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
<.		·		101	7772	5	2	120	108
5		30. Name and address of person who completed cause of death (II			mTMONTE:	3.00 O.*	000		
∍ Sta	ate	DR. TARIQ MAHMOOD 2300 DULA 31. Date filed (Month, Day, Year) 32. Registrar's Sig	net VAI	MOSALE	TIMONIUM	, MD 21	นษ์ว		
Regist	rar	FEB 2 5 2008	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Yea 2.05 AM **Physician** TERPUARY 202008 Linda T Endemann /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner GLE BURNIE BATTIMINE WASHINGTON MEDICAL NTA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 □ F 90 September 18 1917 Estonia 214 44 4595 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 256 Arundel Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 **XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo 3altimore, Maryland 21215-0036 Specify. Completed by White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any lonce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4*o*r 5+) N/A Johns Hopkins University Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Poder Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric Talvik 256 Arundel Road Pasadena, Maryland 21122 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Inc February 21 2008 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility e of Funeral Service Licersee Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) ACU DENT **Physician** /Medical Due to (or as a consequence of): Examiner STIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 2 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has ral director, page 2 performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 h (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rame and address of person who completed cause of death (Item 23a) (Type, Rrint) Day, Year) 32. Registrar's Signature 31. Date filed (Month, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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	Funeral Director		5. Social Security Number 037-22-4913 Usuel Residence of Decedent	G., .O.	Months Days		8. Date of Birth (Month, Day,) Mar 12,	1938 Rhoc	pplace (State or Foreign intry) le Island		
	and		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
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	deatl	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of tf Yes, specify Cul	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Amer Black, White			
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baltimore,			21. Signature of Funeral Service Licer		22. Name and Addr	ess of Facility Comy Board	655 W F	Raltimore	Street		
ă	Depert Import eny inj		Samo 1	Wade, Director	Baltimore.	-		Darcimore	Sticet		
			23a. Part. Enter the disease, or com	plications that caused the death. Do n one cause on each line.				st,	Approximate Interval Between		
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ō	Phys	. To	27. Manner of Death	28a. Date of Injury 28b. T	me of 28c. Inju		28d. Describe how				
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5	s efte	Sert	4 Homelas	building, etc. (Specify)			City or Yours,	J. G.			
	To the Hospital of within 24 hours of To the Funerel D completely filled in		29a. Certifier 1 Gertifying Pt	nysicien: To the best of my knowledge, niner: On the basis of examination and	death occurred at the	time, date and place, opinion, death occurr	and due to the cau	use(s) and manner as	stated. to the cause(s)		
	To the H within 24 To the F complete	Medicai	one)	and manner stated.				d. Date signed (Monti			
	Voit Con	2	29b. Signature and title of certifier		29c. Licer	nse number	290	Col - A.	, 5ay, real)		
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			30 Name and address of person who	completed cause of death (Item 23a) (Type, Print)	TO DA	NO 15	10 Cle 01116	278		
	C.	to	31. Date filed (Menth, Day Year)	32. Registrar's Signatura	MARIE CON	GC 1/	10-	00	01-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend #30, perDVR, g876, 2/25/08 TICertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** F<u>E</u>B 0855 2008 18, ALBERT FIERSUK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CAROLINE DENTON 7881 DYER RD. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday. 6. Sex 5 Social Security Number **Funeral** Months XXM 2□F JUNE 28, MD 1950 57 214.56.5666 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10b. County 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 Yes YY No Director **DENTON** CAROLINE MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21629 7881 DYER RD Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2/1X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) other than ANNE ARUNDEL COUNTY SCHOOLS CHIEF ENGINEER MAINT. MANAGER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH M. LOWE Is marked ALBERT J. FIERSUK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7881 DYER RD., DENTON, MD 21629 Health i WIFE LINDA FIERSUK permit. Pages 1 and Department of Healt Important: If item 21 any injury or other 1 other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition NX Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE, HD CARDENS OF FAITH FEB. 22, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licens FINK FUNERAL HOME, P.A. GREGORY 426 CRAIN HWY. S., GLEN BURNIE, MD FINK M01148 e, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Listony one cause on each line. Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease shock, or heart failure. 1 Mctast Immediate Cause (Final disease of andition resulting in death) iver carcinoma)ee **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed nding physician and use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the death certificate be Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy 23d. Date of delivery use 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably - 4\₩Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy page 2 has performe 2K No Yes After this certificate 26. Place of Death (Check only one) Attending Physician: 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 3 DOA 2 ER/Outpatient 1 Yes 2 No 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No o the Hospital or Attending the Hospital of Attending the Funeral Director; Al completely filled to the Funeral Director; Al 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and thom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Lakshmi Vaidyanathan, MD Faston, MD

2008

31. Date filed (Month, Day, Year)

32/Registrar's Signature

Division or Vital within 24 To the F

Box 68760

P.O.

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 5

NANCY HUTTON

FEB

Registrar DHMH 17 Rev 1/2001 and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

031002

29d. Date signed (Month, Day, Year)

FFBRUARY 20, 2008

		1 - For State of Maryland Registrar		rtment of H			giene Reg. No. 20	08	05619
*		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Day Year	
Physic /Medi		Dorothy	Gross		02			11:20a ^M	
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death rstown	,	4c. County of Death Baltimore	
		Future Care Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. In	ast hirthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of Birt	h I		lace (State or Foreign
Funeral Director		217-05-3281 3□M 2XF 84	Vro	Months Days	Hours	Min. (Month, Day 05 24	/, Year)	Coun	MD
ם פ		Usual Residence of Decedent				PO 21			
arylan show dat	_	10a. State 10b. County 10c. City	, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2☐ No
he Ma 8a-f	Director	MD NA	Bal	timore			10g. Citizen of \	Mhat Cour	
with t		10e. Street and Number		212	15			S.A.	,
teath	Funeral	5706 Key Ave 11. Marital Status 12. Was Decedent Ever in U. S	3. 13. \			in? (Specify Yes or No- Puerto Rican, etc.)		e - Americ	an Indian,
or iter	Ē	1 Never Married 2 Married 1 Tyes 2 No If Yes, Give			in, Mexican, Specify:	Puerto Rican, etc.)		ck, White,	
ours a	dby	③ Widowed 4 □ Divorced Year or Dates:		I∐Yes 2⊠ No			Specify	בם	.ack
15-C	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most	of working	16b. Kind of B	usiness/Ind	dustry
withir ene.	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na		Sorter	7		Posta	1 Wc	rker
d 2 filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother	's Name (First, Middle,	Maiden Surnan	ne)	
yland 21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygiene. Ared other than "natural" or items 23a or 28a-f show atte event, the Medical Examiner must be notified at	To B	George Ward			Addi	e Smith			
E E E E		19a. Informant's Name/Relationship (Type. Print)				r or Rural Route Number	-		
and	, a	Christine Watson-Niece				altimore,		21215	
ges 1 t of H if itel				sition (Name of natory or other place		Date / 26 / 09	20c. Location	•	
ti Pa ti Pa rtmen rtant;		- Bestation of Bestation (speed)		Memoria . Name and Addres	i'	/26/08	Arbutu	15/ 1	
Baltimore, Ma permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Fineral Service Licensee	Ma 43	arch F/H	Wes	t ve, Balti	more,	Md 2	21215
Sylvania and the burial-transit	dical Examiner	Sa. Part1. Enter the disease, or complications 1 at cause the death shock or heart failure. List only one cause on each line. In media: Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Lines or dearping. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the cond	uence of):	divnu	opu	thy			onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit or the state of the st	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy	<u>'</u>		1	ate of delive	ery Day Year
rds, P quires that n signed b	β	Part II. Other significant conditions contributing to death by not result to be	ilting in the u	nderlying cause giv	en in Part I.		obacco use con Yes 2 No	tribute to ti 3 ☐ Prob	he cause of death? pably 4 Onknown
or Vital Records, Physician: The law requires t r this certificate has been signe rral director, page 2 should be o	Completed	1t ypatenso	2/			24a. Was autoj perfo		Were auto prior to co death? 1 \(\sum Yes	ppsy findings available mpletion of cause of
Vital F ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		t all post Oth	or.	of Death (Check only o			
Or Physical this call direction	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ER/Outpatier 28b. Time o	II 3 DOA	4 Nur	rsing Home 5 Resi	dence 6 Otl		(y)
ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year)	Injury	Wor	k?¨ Yes 2∐ N		now injury occur	100	
Division or Vita of or Attending Physician: after death. Director: After this certification by the funeral director,	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Place of injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (i City or To	Street and Num wn, State)	ber or Run	al Route Number,
Hospita 24 hours Funeral etely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knor 2 Medical Examiner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tivestigation, in my o	me, date an opinion, dea	d place, and due to the the time,	cause(s) and m	anner as s , and due t	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number	-(1)	29d. Date signe	ed (Month,	Day, Year)
1		1 mo		1	リア	7367	212	2101	8
H		30. Name and addless of person was completed cause of death (Item	23a) (Type,	Print)	(7569 Teene Tr	ue 1/4	2/	7/1208
Si Regis	tate trar	31. Date filed (Month, Day, Year) FEB 2 5 2008 32. Registrar's Signa	ture	enter .	,				VI- V

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: After I Director: d in by the within 24 hours aft

To the Funeral Di

completely filled in

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide

29a. Certifier

(Check only one)

6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

D64395

29d. Date signed (Month, Day, Year) FEBRUARY 22, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NCHAPLES ST, SUITE 209 BALTIMIZE MD 21264 DANIEUE DUBERMAN, MO 31. Date filed (Month, Day, Year)

State Registrar

Medical

FEB 2 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day GRAGER Physician 22 2018 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** JOHNS HOPKINS MEDICAL CENTE BALTIMORE BAYVIEW Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number Min. Days Hours **Funeral** 07/25/1964 167 56 7984 MARYLAND 43 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 1 Yes 2 No Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medica Examiner must be notified at BALTIMORE BALTIMORS MN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ころくろりとう ことろろろし Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11, Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE altimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ROOFING Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. ROOFFR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DEESTER CHILDRESS should be fi and Mental I DORCAS PRICE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is in any Injury or other traum once. ALBERLE LANE, MIDDLERIVER, MD DUBUSK/NEPHELL MICHAEL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State HANOVER MARYLAND 25/2008 MDENT CREMATION 4 □ Donation 5 □ Other (Specify) 21076 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ARDENT CREMATION 7500 CONNELLEY DR, N. HANDVER MD Laura C. Hardesty M-01197 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): COHOL CONSUMPTION Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 9□Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown SUNDROME 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 1 Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number ure and title of gertifier 29h. Signa 2008

BALTIMORE,

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14940 EASTERN AVENUE

and address of person who completed cause of death (Item 23a) (Type, Print)

MD

WILLIAMS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 23, 2008 Lily Gilcrest 9:45 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6831 South River Drive Middle River Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 10/11/1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 X F 017-16-7556 England Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits or items 23a or 28a-f shormliner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6831 South River Drive 21220 U.S.A. death by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or items edical Examiner m ould be filed within 72 hours after of Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify Specify: 3 KNVidowed 4 □ Divorced White Completed Is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Johnson Ada Mason ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Gilcrest (Daughter) 6831 South River Drive, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2008 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or or difficon Approximate Interval Between Onset and Death Physician Due to (or as a consequence of): disease or condition resulting in leath) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? res 2 X No certificate 1☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number BOUYUZUS 2/25/08 meiner m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1205 York Rd Ste 32C Lutherville Md 21093 June Breiner Min 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State FEB25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene.

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Medical Mary Cally Cr			
4. Chy Tourn or Location of Doath	16 2008 8:44 AM		
The Johns Hopkins Hospital Baltimore, City			
Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-25-1	9. Birthplece (State or Foreign Country) MD		
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits		
MD N/A Baltimore	1 ☐ Yes 2 ☐ No		
106. Street and Number 107. Zip Code 21202	itizen of What Country? USA		
MD N/A Baltimore 109. Ci 109	14. Race - American Indian,		
10a. State 10b. County 10c. City, Town or Location Baltimore 10d. Zip Code 10g. City 10d. Zip Code 10d. Zip Co	Black, White, etc. Specify: Black		
The state of the s	Kind of Business/Industry		
Elementary/Secondary (0-12) College (1-4or 5+) L College (1-4or 5+) L L	ibrary		
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20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)	ocation - City or Town, State Randallstown, MD		
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23a. Part) Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician (Medical (Medi	Approximate Interval Between Inset and Death MINUTES		
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fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
The sulting in death) Last Due to (or as a consequence of):			
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
Sause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in death) Last Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause (Disease or injury that intitated events resulting in the underlying cause given in Part I. Cause	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death? No 3 Probably 4 Unknown		
Alzhamers Discase 1 Yes 2 Alzhamers Discase 24a. Was an autopsy periodical examiner? 1 Yes 2 Alzhamers Discase 25. Was case referred to medical examiner? 1 Yes 2 Alzhamers Discase 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?		
To be a construction of the construction of th	0 15 163 25 110		
I inpatient 22(en/Outpatient 3 DOA 4 Indisting notine 5 Hesidence	pe now injury occurred		
I inpatient 22(en/Outpatient 3 DOA 4 Indisting notine 5 Hesidence	ary occurred		
28b. Date of Injury Second Color Color	and Number or Rural Route Number,		
28b. Date of Injury Second Color Color	and Number or Rural Route Number, te) s) and manner as stated.		
The state of the s	s) and manner as stated. In place, and due to the cause(s)		
The state of the s	s) and manner as stated. In place, and due to the cause(s)		
The state of the s	and Number or Rural Route Number, te) s) and manner as stated. nd place, and due to the cause(s)		

DHMH 17 Rev 1/2001

08-01441	
Lucille Gaines	

ucille Gaines		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Middle, Last) AUCI/IC V. Gaines 2. Date of Death Month Day Year February 19, 2008 1106 hrs
Neurcai Exami	ei	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 3 3 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4
r death with or items 23 must be no	by Funeral Dire	Usual Residence of Decedent 10a. State
215-0036 be filed within ntal Hygiene rked other tha	Be	Elementary/Secondary (0-12) College (1-4 or 5+) C
Physician /Medical `xaminer	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Peritonitis Due to (or as a consequence of): b. Ischemic bowel with perforation Due to (or as a consequence of): c. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): d.
P.O. Box 6876 es that the death certificate igned by the attending phyoe detached for use as the U	hysician/I	UNPENDED
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Certification: To Be	25. Was case referred to medical examiner? 1
3 Sta	ate	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature
Registr		FEB 2 5 2008 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** FEBRUARY 22 3008 GOINS TAMAS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
r 1 Year | If Under 24 Hrs.
Days | Hours | Min. JOHNS HOPKING BAYVIEW MEDKALCENTER 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ 1 213-62-8148 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with I Hygiene. Ather than "natural", or Items 23a or 3 Force mo 21206 Funeral Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 All Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) ourt Clerk District Court is marked other Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, t once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be I Joseph Barney, Sr.
19a. Informant's Name/Relationship (Type. Print) Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Burney /sister WD 3BOX Force Ad Baltimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/28/2008 Baltimore, MI) 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vagon C. Greene Funeral Services 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Bultimore MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WOUND INFECTION 3 WEEKS POLYMICEOBIAL /Medical Due to (or as a consequence of): Examiner YEARS MULTIPLE SCLEROSIS WITH LEG CONTRACTURES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Ves 2 No
9 Vinknown Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown n signed by th 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Nonknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Consiss Walker Hours RES-000 FEBRUARY 22,2008

State Registrar

DHMH 17 Rev 1/2001

FEB25

VANESSA WALKER

31. Date filed (Month, Day, Year)

37) Registrar's Signature

MO

HARRIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVE

BALTIMORE, MD 21824

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Grotto 2:30P Josephine 02. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimre 4405 Bayonne Avenue If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) NY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔭 F 97 03.19.1910 Director 070.26.3236 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mines because once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 AYes 2 No Baltimore N/A Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 4405 Bayonne Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Machines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Unknown Frank Zammiello 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4405 Bayonne Ave., Baltimore, MD 21206 Mary Reagan/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02.21.08 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive proximate erval Between iset and Death 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) JULIS **Physician** /Medical Examiner The law requires that the death certificate be executed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and attending physician for use as the burla

	is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line.	Inte
,	Congestive heart failure	3,
	Due to (or as a consequence of):	
)		
	Due to (or as a consequence of):	
·		
	Due to (or as a consequence of):	
ı		

Physician/Medical 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ğ Completed

Be

Certification: To

Medical

as

detached

23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 4☐Pregnant at time of death 9☐Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 ☐ Yes 2	No 3□	Probably	4 □Unknov
	24a. Was an autopsy performed? 1□ Yes 2♥ No	prior t death	o completic	dings availab on of cause o
26. Place of Death (Check only one)			

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death 1 Naturai 2 Accident 3 Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Carla way

D31025

29d. Date signed (Month, Day, Year)

State Registrar

Rosenthal, M.D. 3414 St Paul Street, Bullimore MD 21218 32: Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Korenthul M.D.

FEB25



Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

filled in by

completely within 24

and Mental Hyg	llene							
	eg. No. 2	0	0	8	0	5	6	2

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	Physici /Medic Examin Funeral Director	al	4
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	
Division or Vital Records, P.O. Box 68760, 🔻	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and burial-transit.	Medical Certification: To Be Completed by Physician/Medical Examiner	

1 - State Registrar	Otato of Marylan	Cer	tificate of	Death	I I I I I I I I I I I I I I I I I I I	Reg. No. 2	008	051	527
1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath Day	Year	3. Time of	Death
Richard Keith G	aris					ary 12		3:30	PM M
4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Dea	ith	4c. Cour	nty of Death		
Washington Adve	ntist Hospital			Takoma		,	tgomer	Y	
187-40-8381	Sex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days			h y, Year) /1954	9. Birthpl Count VA	ace (State o	r Foreign
Usual Residence of Decedent 10a. State 10b. County	10c, Cit	y, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·		10	d. Inside Ci	ty Limits
, , , , , , , , , , , , , , , , , , , ,								1 ☐ Yes	2 X No
MD Anne A	Arundel Mi	llersv	10f. Zip Code			10g. Citizen o	of What Count	rv?	
	" 0 4		21108	2			ed Stat	-	
611 Waterwheel I	12. Was Decedent Ever in U	.S. 13. V	Nas Decedent of	Hispanic Origin? (Specify Yes or No	- 14. R	lace - America	ın Indian,	
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 No			ban, Mexican, Puè	rto Rican, etc.)	В	lack, White, e	etc.	
3 ☐ Widowed 4 🔣 Divorced	If Yes, Give Year or Dates: 1975-	84	I∐Yes 2⊠No	Specity:		Spec	^{cify:} Whi	te	
15. Decedent's 8 (Specify only highest g	Education	16a. Deced	tent's Usual Occu	ipation e during most of w	orking		Business/Ind		
Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retir	ed)	orang .	Inter	rior De	esign	
0	4	Inte	rior Des	signer /					
17. Father's Name (First, Middle, Las	st)				ame (First, Middle,		ame)		
Charles Richard	Garis				Marie Stem				
19a. Informant's Name/Relationship	,	1			Rural Route Numbe			Code)	
Jarrad J. Garis/				St. Summ	erville,			-	
20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, cren	sition (Name of natory or other pl ake Crem	i i	Feb 16 2008		n - City or To		and
21. Signature of Fyneral Service Light	Moosi Moosi	002	Rapp Fundage 933 Gist	eral & Cre	emation Se lver Sprir	ervices	yland 2	0910-	
23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the deat ly one cause on ,, ch line.							Approximat Interval Bet Onset and I	ween
Immediate Cause (Final disease or condition resulting in death)	_a. Muse,	· colo	n 1	Jailu	re-		j		
resulting in death)	Due to (or as a consed	uence of):	1 0	0 0	0 :				
Sequentially list conditions,	b. Due to (or as a naseq	Car Gu	cal 1	Hulant	Hoch				
Sequentially list conditions, if any, leading to immediate cause. Enter ordenlying Cause (Disease or injury	Due to (or as a miseq	derice oi).	1. 1.	\mathcal{O} .	1				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as a conseq	uence of):	grace	y VIC	rease				
IE EEMAI E			•						
	d								
	23c. If yes, outcome pf pregna					23d. I	Date of delive	ry	
in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pregnan Other (specify)	cy					Year
9 ☐ Unknown	9□Unknown								
Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause g	îven in Part I.	23e. Did t	obacco use co	ontribute to th	e cause of c	leath?
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions					1 🗆 '	Yes 2∏ No	3 ☐ Prob	ably 4 🖼	Unknown
					24a. Was	an 24	b. Were autop	osy findings	available
					autor	psy prmed? 2 No	death?		ause of
25. Was case referred to medical				26 Place of D	1 Yes eath (Check only o		1 🗆 Yes	2 □ No	
examiner? 1 Yes 2 No	Hospital:	ER/Outpatien	ıt 3□ DQA O	ther:	Home 5 ☐ Resi		Other (Specific	/)	
27. Manyler of Death	28a. Date of Injury	28b. Time of			28d. Describe			<u>'/</u>	
1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) on	Injury		ork? ∐Yes 2∐No					
3 ☐ Suicide 6 ☐ Could not	be 28e. Place of injury - At he	ı ome, farm, str	eet, factory, office	9	28f. Location (mber or Rura	l Route Nun	nber,
4 ☐ Homicide determine	building, etc. (Specin	fy)			City or To	wn, State)			
29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death ation and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. the cause(s)
29b. Signature and title of certifie	1		29c. Licer	nse number		29d. Date sig	ned (Month,	Day, Year)	
•	2022		25	2883		2/18	2/00		
30. Name and address of person with	o completed cause of death (Item	n 23a) (Type,	Print)	uii A	T. 12.	PI) 11	20	912
31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature _	Hue. Ti	170	100100009	1011	- 1000		6.2
	008	· And	1						
FEB 2 3 Z	100	The state of the s							

Registrar

3+1

signed to Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Be Completed by

Certification: To

Medical

thin 24 hours a

1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□Unknown	Jean Ollower (Gpccity)								
		ontributing to death but not res		cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
					24a. Was an autopsy performed 1∐ Yes 2 ☑							
25. Was case referred to medical			26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐	No.	Hospital: 1 Inpatient 2	ER/Outpatient 3□ [OOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)						
27. Manner of Deat 1 Natural 2 Accident	h 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred						
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factory)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)	2 ☐ Medical Exam	and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)						
29b. Signature and	title of certifier	ABAK BEDA		9c. License number	29d.	Date signed (Month, Day, Year)						

RES 0001

Geath (Item 23a) (Type, Print) 3001 S HANOVER AVE, BALTIMORE, 11

FEB, 18, 2008

Registra DHMH 17 Rev 1/2001 BEDAYAZ

MD egistrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 05629 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year HILL ATHLEEN 7:35 PM /Medical FEB 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–23–1937 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF 70 216-36-6185 Director Maryland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e Street and Number 1907 Yorkie Ave. ms 23a or Funeral death items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status an "natural", or iter Medical Examiner Black, White, etc 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Homemaker Own Home and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown ဂ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Denise Stuart, daughter Department of Health Important: If Item 27 any injury or other troone. 1907 Yorkie Ave. Pasadena, MD. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel or the place ory 02-20-08 Odenton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Poneral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY DISTRESS SYNDROME **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of certificate be executed use as the burial-transit ACUTE PNEUMONIA DAY and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical SEPTIC SHOCK 1 DAY IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HYPERTENSION INELLITUS 11 DABETES 1 Yes 2 No 3 Probably 4 Unknown Completed HYPER UPIDEMIA 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has DISEASE this certificate COLONARY ARTERY 1□ Yes 2 ANO 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 2 Il Director: After this id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES ODDA FEB 2008 RESIDENT 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print) M.D. DENNIS TERMULC 3001 S HANDVER ST. BALTIMORE MD 21225 31. Date filed (Month, Day, FEB 2 5 32. Tegistrar's Signature State 2008 E SELVE Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 9:36 PM **Physician** VIRGINIA L. HENDRICKSON February 23 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE N/A UNION MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 👿 F 82 Yrs. 216-22-5565 9/29/1925 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No WHITE MARSH MD BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21237 USA 5418 BRIGHTLEAF COURT Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√∑ No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) marked other than the TRAFFIC DEPARTMENT WBAL 12th GRADE permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARA BELLE WENNER OLLIE McCREY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1109 N. HOWARD STREET ALEXANDRIA, VA 22304 EDWARD HENDRICKSON/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Speçify) CATONSVILLE, MD METRO CREMATORY, INC. 2/25/2008 22. Name and Address of Facility 21. Signature of Funeral Service Licenses THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN_BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner = rdo curditus Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit rost and Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown as been signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

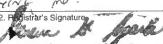
1 ☐ Yes 2 ☐ No 24a Was an autopsy page 2 X No 1∐ Yes or Attending Physician; the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 2 1 ☐ Yes 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 ☐ Pending investigation After 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours atter death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 🗡 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, Balt, MD MO Maurice 31. Date filed (Month, Day, Year) FEB 2 5 2008 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:00 p James Hamlette. Jr. Feb 18, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 8511 Greens Lane 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday. 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 □ F Dec 27, 1947 Maryland 60 Director 220-50-0837 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21244 8511 Greens Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after ∏Yes 2 No f Yes, Give ∕ear or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ∏ Yes 2 DMNo Specify Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Of Maryland permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Bell Hamlette James E. Hamlette ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9010 Samoset Road Randallstown, Maryland 21133 Melissa Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. 02/27/08 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each lin. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** motumon /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending pl IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 **Y**No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy nerformed? certificate 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide É 4 ☐ Homicide filled in thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ₹ ° D15938 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUNTON GYIN

State

31. Date filed (Month Day, Year) 5 2008 Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Physician Month 1:15 AM M 2008 February 10, /Medical Jonathan_ Hall 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 96 Yrs DC Director 02/06/1912 216-46-0136 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. . other then "naturel", or items 23e or 28e-f show vent, the Muchosi Examiner must be notified at 1 Yes 2 No Director Kensington MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20895-Funeral 10501 Drumm Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Higher Education Elementary/Secondary (0-12) College (1-4or 5+) **Biology Professor** or other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any findry or other treumatic event 9058. 17. Father's Name (First, Middle, Last) Be Ethyl Zoe Taylor Percival Hall 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Newton St. Silver Spring, MD 20902-Peter Jonathan Hall/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 Bonation 5 ☐ Other (Specify) 2008 Uniformed Services 21. Signature-of M00382 22. Name and Address of Facility Rapp Funeral & Cremation Servi 933 Gist Ave. Silver Spring,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA **Physician** /Medical Due to (or as a consequence of) Examiner ASPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ellending physicien and or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed) certificete 1 ☐ Yes 2 1 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina To the note that within 24 hours after death.

To the Funeral Director: Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29c. License number 29d. Date signed (Month, Day, Year) 29h Signature and title of certified D0061937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CANDARE L. WILSON, MD - 1500 FOREST GLEN RID, SILVER SPRING, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 5 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Harold Johnston 2008 12:01 AM 2 QUUIS Feb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville 3515 Branch Court Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**20** 2 🗆 F Months 217-26-4589 84 21 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 ☐ Yes 2X No Director Parkville Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 S 3515 Branch Court Road

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 21 Married l □Xes 2 □ No f Yes. Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Dept Truck Driver 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Taylor John Lewis Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3515 Branch Court Road Pikesville, MD 21234 Shirley Johnston-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1☐Burial 2 ☐Cremation 3 ☐Removal from State 4☐Donation 5 ☐Other (Specify) 2-27-2008 Owings Mills, MD Garrison Forest MarchF/H East 22. Name and Address of Facility AB202 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia Advanced Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, use as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 TNo been signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part ii, Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 ☐ Yes 2500 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an MI page 2 s 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ ₩ Certification: To 27. Manner of leath funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After 1 (Month, Day Year) 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41215

Registrar
DHMH 17 Rev 1/2001

timore

MD 21201 Mark D. Heuser

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

32. Registrar's Signature

North

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		, roi	ertificate of Death	nemai mygiem Reg. No	Z 11 11 6 11 3 b 3 b
Physi	ician	1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death
/Me	dical	BRUCE HOWARD JONES	4b. City, Town, or Location of Death	February	16, 2008 1:45 A M
Exan	niner	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	Frederick		Frederick
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdox 13 - 84 - 5834	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) معرف
e Maryland 8a-f show itified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	niddle town		10d. Inside City Limits 1
th with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 6827 Picnicwood Rd	10f. Zip Code 31769		itizen of What Country?
IOTE, MISTYISHIG ZIZISJOUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Healin and Mentall Hygiene. If of Healin and Mentall Hygiene. or other traumatic event, the Medical Examiner must be notified at	۾	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (So If Yes, specify Cuban, Mexican, Puerlo 1 ☐ Yes 2 ☐ No Specify:		14. Race - American Indian, Black, White, etc. Specify: Whit-
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king	Kind of Business/Industry
	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	ntertainment
	7	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Ru		or Town, State, Zip Code)
MOFE, Pages 1 an nent of Heal int: If item 2			sposition (Name of crematory or other place)	Date 20c. I	ocation - City or Town, State
두 구 된 된 글	ouce.	21. Signatur of Fundal Service Conser	22. Name and Address Cility		Jessy, DA 18434
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Approximate Interval Between Onset and Death
tificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
death cer attending of for use	Physician/Medical		23d. Date of delivery Month Day Year		
requires that the een signed by the	۾	Tarri. Stilet significant contains continuing to death but not recalling in the	e underlying cause given in Part I.		ouse contribute to the cause of death?
The law requires ate has been sign page 2 should be	Completed			24a. Was an autopsy performed?	
VITAL sician: 1 certificat rector, p	Be	25. Was case referred to medical examiner?	Other	th (Check only one)	
OF Physer this eral di	1 P	1 Inpatient 2 EH/Outpa	e of 28c. Injury at	28d. Describe how inj	6 ☐Other (Specify) ury occurred
ath. or: Afte	atio	1 Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION OF VITAL INC. To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)		City or Town, Sta	<u> </u>
ne Hospi 124 hou ne Funei	Medical		eath occurred at the time, date and place or investigation, in my opinion, death occu	r, and due to the cause urred at the time, date a	(s) and manner as stated. Independent of the cause (s)
To the within To the comp	Me	29b. Signature and title of certifie	29c. License number 140061791	29d. D	oate signed (Month, Day, Year)
3		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 50 Thomas John	sond Fr	red MD 21702
	State strar	- K	book)		1
DHMH 17 Rev	-	FFB 4 3 ZUU0 SCHOOL			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician STINE Koukoulas 2008 chruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore IChRIST 100 USON Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country.) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 □ 212-46-5372 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Director MD Imore 10g. Citizen of What Country? 10e. Street and Number 1.5.A 21224 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify Specify: White 3 ₩idowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Hanzican Stan tinou ပ KOLARIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joula Konkowlas-Woods-Daughka 20b. Place of Disposition (Name of cemetery, crematory or other place) 724 Hmore, MD 21224 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-25-08 Wadlawn 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brad /e4 - ASNOW Willow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ure **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Fother (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. Ms

740 A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

ear

Year

1 ☑Yes 2 No

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

6701 32. Sgistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PASOUA LUMARO FEBRUARY 19 2008 5:00 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2120 WOODBINE ROAD WOODBINE HOWARD COUNTY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, 08 / 06 / 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ITALY Months 1 M 2 F 82 Director 216 54 3082 Usual Residence of Decedent 10c. City. Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD BALTIMORE RASPEBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4428 HAMILTON AVENUE items 23a r than "natural", or items 23a 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: WHITE <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) N/AN/ASEAMTRESS CLOTHING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FILIPPO LUMARO CONCETTA 0 BARRESI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY GUGLIOTTA/SON IN LAW 2120 WOODBINE ROAD WOODBINE, MD 21797 se of Disposition (Name of Date 20c. Location - City or Town, Stat 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Injury or 1 → Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 2/22/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the all Sewice licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME any 1211 CHESACO AVE BALTIMORE, 21237 MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ogenous month /Medical (or as a consequence of Examiner Due to (of as a consequence of): Insil Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached the 9□Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 pe 20 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother} \) Other (Specify) \(\text{DAUCHIERS HOME} \) 3/1 No Hospital: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: Attending 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

11ChAF

29b. Signature and title of certifier

Philopel -WERBOCK 32. Registrar's Signature

9116

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

	i i	sic ed mi
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and
か	4	

	For	Гуре or Print in BI State of Maryland	/ Department of H	ealth and Mental I	and the same of the same of		
	1 - State Registrar		Certificate of L		Reg. No.		
Physician	1. Decedent's Name (First, Middle, Last Almeta Ladler-I	ickerson		2. Date o		3. Time of Death	
/Medical				Febru			
Examiner uneral	4a. Facility Name (If not institution, give 5	of Baltimore 7. Age (In yrs. las	Ba 14:	If Under 24 Hrs 9 Date o	4c. County of EN A	eath Birthplace (State or Foreign Country)	
rector	411-94-9340	□M 2 X F 52	Yrs. World's Days	Aug.	23,1955	TN	
fied at fed at tor	Usual Residence of Decedent 10a. State 10b. County N /		Town or Location Baltim	ore		10d. Inside City Limits	
23a or 28e ust be noti	10e. Street and Number 2503 Violet Ave	enue Apt.110	1 South 2	1215	10g. Citizen of What	1	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3√√Vidowed 4 □ Divorced	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc Specify:	14. Race - A Black, V Specify: I	merican Indian, Vhite, etc. Black		
Medical E	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of working	16b. Kind of Busine	,		
the the	11th Grade	College (1-4or 5+)	Housew			Home	
arked other atic event	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Mi Ruth Taylor	ddle, Maiden Surname)	,		
n 27 Is m ier traum	19a. Informant's Name/Relationship (To Sonya C. Murphy	y/ Sister		Avenue Bal	timore, Ma	aryland212	
or oth	20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ I	20b. Pla Removal from State	ace of Disposition (Name of metery, crematory or other plac	Date	20c. Location - City		
ury o	4 □ Donation 5 □ Other (Specify	Gre	enmount Cem				
Import any Inj once.	21. Signature of Funeral Service Licens	Varr		^{ss of Facility} Chatma sterstown Rd			
To the Funeral Director: After this certificate has been signed by the attending physician and sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit sompleted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injer) that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.	rdial Infarct ence of): Artery C ence of):)iscase			
d by the attending physic letached for use as the but a physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23d. Date o	f delivery Day Year				
igned by be detac	Part II. Other significant conditions of	Did tobacco use contribu					
sen s nould ted	i -	les Mellitus			TENTES ZUNO SE	Probably 4 Unknow	
cate has been s page 2 should Completed	COP	b er tension		1	autopsy prio performed? dea	e autopsy findings availab r to completion of cause of th? Yes 2 ☐ No	
sertiflic sector, Be (examiner?			26. Place of Death (Check of	only one)		
this c	1 1es 2 140		R/Outpatient 3 DOA Oth	4 Nursing Home 5		Specify)	
ral Director: After ted in by the funeral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)		Yes 2 □ No	ribe how injury occurred	av Dural Bouta Mussia	
led in by	4 ☐ Homicide determined building, etc. (Specify)						
o the Fune ompletely fil Medical	29a. Certifier 1 X Certifying Phyone) 1 Medical Example 2 Medical Example 1 Medical	ysician: To the best of my know niner: On the basis of examination and manner stated.	viedge, death occurred at the ti ion and/or investigation, in my o	me, date and place, and due to ppinion, death occurred at the	o tne cause(s) and manne time, date and place, and	er as stated. I due to the cause(s)	
Tot	29b. Signature and title of certifier		29c. Licens	e number	29d. Date signed (A	fonth, Day, Year)	
	3	Μ.Δ.	Δ5	7062	February	21 , 2008	
	30. Name and address of person who compared to the second of the second	completed cause of death (Item)	23a) (Type, Print) Belvedere 6	altimore MA	21215	- 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure dearly				
Registrar	FEB 2 5 200	10 January 18	7-9				

		Please Type or Print in Black Ir	ndelible Ink.	Ensure All	Copies Are	Legible.					
		State of Maryland / Dep			ntal Hygien	e	05000				
		1 - State RegIstrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death									
Physicia	_	Augustina J. LaCorte				ay Year	3. Time of Death				
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		c. County of Death	7				
		St Agnes Hospital	N/A								
Funeral Director		5. Social Security Number 114-09-4632 6. Sex 1 P 7. Age (In yrs. last birthday 1 P 1 P 1 P 1 P 1 P 1 P 1 P 1 P 1 P 1	Months Days	Hours Min.	Date of Birth (Month, Day, Yea ept. 5,	r) Coi	hplace (State or Foreign untry) V York				
and ww		Usual Residence of Decedent 10a_State Maryland 10b. County Baltimore 10c. City, Town or Catonsvil	ocation				10d. Inside City Limits				
e Maryl a-f sho tiffed a	ctor	Maryland Baltimore Catonsvil	тте				1 ☐ Yes 2 ☐XNo				
ath with th	ral Director	10e. Street and Number 719 Maiden Choice Ln. HR120	10f. Zip Code 21228		USA						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ANo	dispanic Origin? (Speci an, Mexican, Puerto Ri Specity:	ify Yes or No- can, etc.)	rican Indian, e, etc. Vhite					
in 72 ho "natur fedical	Be Completed	(Specify only highest grade completed) (Giv	edent's Usual Occup le kind of work done DO NOT use retire	oation during most of working d)	16b.	Kind of Business/I	ndustry				
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hould d Men marke matic	ဥ	Guiseppi LoCurto 19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street	Gesuala M			Zin Cada)				
and 2 slealth an 27 is refer traur			-	View Place			, ,				
Pages 1 a nent of Hea int: If Item		20a. Method of Disposition 20b. Place of Disposement of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other pla	ce) Da		Location - City or					
t. Pag tment tant: I ijury o		4 □ Donation 5 □ Other (Specify)		lál Gardens		, Annapo	olis, MD				
permit. Departi Importa any inj				ineral Home nur Spring		· true MD	. 21227				
0.00		23a, Part1. Enter the disease, or complications that caused the death. Do not e	Approximate Interval Between								
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of):									
/Medical Examiner		resulting in death) Due to (or as a consequence of):	11	+	7	,					
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that the	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacci	use contribute to	the cause of death?				
quires on sign uld be	ed by				1 ☐ Yes	2□ No 3 □ Pr	robably 4 □Unknown				
ne law re has bee ge 2 sho	Completed				24a. Was an autopsy	24b. Were at	utopsy findings available				
. The pate he page	Com				performed? 1□ Yes 2□		completion of cause of				
sician: certific	Be	25. Was case referred to medical examiner? Hospital:	O#	26. Place of Death							
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ath. or: Afte	atio	1 □ Nettūral 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		rk?]Yes 2 □ No							
or Atter fter de Directe in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm, s building, etc. (Specify)	street, factory, office	28	3f. Location (Street City or Town, St		ıral Route Number,				
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 112 certifying Physician: To the best of my knowledge, de									
the Ho iin 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my	opinion, death occurre	d at the time, date a	and place, and due	of the cause(s)				
To To To Control	2	29b. Signature and title of certifier	29c. Licen	se number	29d. [Date signed (Mont	h, Day, Year)				
V		29b. Signature and title of certifier 30. Name and address of poisson who completed cause of death (Item 23a) (Type 23a). Date filled (Month, Day, Year) FEB 2 5 2008	e, Print) a / Leu	Chor	elan	Car	Toward 1				
Sta Regista	ite 'ar	31. Date filed (Month, Day, Year) 32. Tegisetrar's Signature FEB 2 5 2008	certe				427				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🚣 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 9:28 A.M FEBRUARY 21, 2008 DREAMA D. LOGSDON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY SINAI HOSPITAL Year If Under 24 8. Date of Birth (Month, Day, Yea 9/30/1941 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F VIRGÍNIA Director 213-40-2316 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County r 28a-f show notified at 1 TYYes 2 □ No Director MD N/A BALTIMORE CITY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be USA 14. Race - American Indian, 5115 WHITEFORD AVENUE 21212 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? , or items 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: ò 3 Widowed 4 Divorced WHTTE 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATEOF MARYLAND CLERICAL the 12TH GRADE Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREW W. SNYDER VIRGINIA M. MARTIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 66 DENDRON COURT BALTIMORE. MDVICTORIA M. LOGSDON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2008 GARDENS OF FAITH CEM. PARKVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. eath 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Approximate Interval Between Onset and Death Part1. Enter the disea *, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart Failure **Physician** -ongestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate outce. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 25 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 032543

10

Registrar

5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark R. Stronberg, M.D. 6191 N. Charles Street Baltimore, May land 21204

31. Date filed (Month, Day, Year)

32. Registrates Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

8.17.18, perFH.9876, 2/25/08 The difference of Booth

		•	1 - For Amend 8,17,18,	State of Maryland perFH,g876, 2/25/0	d / Departmer Departmer Certification	nt of Health and I te of Death	Mental Hyg	iene 008	05640		
	Physici /Medic		1. Decedent's Name (First, Middle, La HENRIETT	ARL	EWIS		2. Date of Death	19 08	3. Time of Death P		
	Examir	er	MOKTAWEST	e street and number) HUSILIAL	KAN	Town, or Location of Death		BALTIN	10KE		
	Funeral Director			Sex 7. Age (In yrs. It	Yrs. Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	1729/19309. Birth	place (State or Foreign intry)		
	Aaryland f show	'n	10a. State 10b. County	10c. City	×1			10d. Inside City Limits 1			
	or 28a-	Director	10e. Street and Number		2/+1mon	p Code	11	0g. Citizen of What Co	untry?		
	death w	Funeral	1030 上・33年 11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. Was Dece	21218 Ident of Hispanic Origin? (S pacify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Amer Black, White			
920	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or Items 23a or 28a-f show ther than "naturel", or Items 23a or 28a-f show ont, the Medical Evaninar must be notified at	þ	1 Never Married Married Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 🗆 Yes	<u> </u>	o 110an, 010.	Specify: Blo	adC		
21215-0036	in 72 hours n "naturel", dedical Exa	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usu (Give kind of we life. DO NOT to	ual Occupation ork done during most of wor use retired)	rking	16b. Kind of Business/I	ndustry		
1212	led with tygiene. her thai		17. Father's Name (First, Middle, Last	College (1-4or 5+)	Die	tician	ne (First Middle M	Maiden Sumame)			
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Man	s 1 and 2 should be filed within 72 ho Health and Mental Hygiene. Item 27 is marked other than "natur other treumatic event, the Medical		19a. Informant's Name/Relationship	Type, Price and Language	19b. Mailing Addres	s (Street and Number or Ru	ral Route Number	City or Town, State, Z	ip Code)		
ore,	permit. Pages 1 and 2 Department of Health : Importent: If item 27 i any injury or other tre once.		20a. Method of Disposition Burial 2 Cremation 3	20b. Pl	lace of Disposition (Na emetery, crematory or	nme of other place)	Date	20c. Location - City or	Γown, State		
Baltimore,			*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lies	5) NA	J MOMOCI 22/Name a	nd Address of Facility	25/1000	ral Serv	ices		
B B	P G E E G		23a. Pert1. Enter the disease, or com	nolications that caused the death	29 Do not enter the mo	5 York 7d	Baldo or respiratory arre	MD ZIZI	Approximate		
	Physician	i.	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	- CRAN		MO FRH.		Interval Between Onset and Death		
	/Medical Examiner		resulting in death) Due to (or as a consequence of): ATRIAL FIBRILLATION								
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
8760,	cate be executed ohysician and the burial-transit		that initiated events resulting in death) Last	CDue to (or as a consequ	uence of):						
9		Aedicai	US SELVANS	d							
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rds, P	quires that the signed by all did be detacted	ed by PI	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tot	bacco use contribute to es 2. No 3 □ Pr			
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Vital		Be	25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only on				
n of	ding Physicien: The th. h. h. After this certificate ha funeral director, page	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?		ence 6 Other (Spectow injury occurred	any)		
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	o the Hithin 24 o the Fi	Medical	one) 29b. Signature and title of certifier		ate signed (Month, Pay, Year)						
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	5		A. MAHESWWA	XRI, MD, N9	DICTHWEST	HOSPITAL	, RAND	MISTOWN	amo		
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			1 - State Registrar		0.57				
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	/Medic		4a. Facility Name (If not institution, give street and nul	nie D. Law		or Location of Death	Te bruw	4c. County of D	60
	Examin	ei	Good Samaritan h	ospital	BaH	imore			N/A
	Funeral	7	5. Social Security Number 6. Sex 1 1 M 2 F	8. Date of Bir (Month, Da	th ly, Year) 9.1	Birthplace (State or Foreign Country)			
ď,	Director		214-66-5579 Usual Residence of Decedent	51	Yrs.		Nov	26, 1956	Maryland
	/land low at		10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
	a-f sh	ctor	Maryland N/A			Baltimore			1 DKYes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	
	s 23a	eral	5416 Price Avenue	edent Ever in U.S.	10. Was Decedent of L	21215	poifu Vac or No		J.S.A. merican Indian,
	fter de ritem iner r	Funeral	Armed Fo	rces? 2 □ No	13. Was Decedent of H If Yes, specify Cub		Rican, etc.)	Black, W	/hite, etc.
980	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Gi		1 □ Yes 2 □ No	Specify:		Specify:	Black
2-003	72 ho 'natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	168	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ring	16b. Kind of Busine	ess/Industry
2121	within ene. than	Idm	Elementary/Secondary (0-12) College (-4or 5+)	life. DO NOT use retire	^{d)} Driver		Iron Mo	untain Medical
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an		To Be	William Lawhorn S	r.			Thelma	Lawhorn-Edw	/ards
Maryland	S S S		19a. Informant's Name/Relationship (Type. Print)	19	b. Mailing Address (Street	and Number or Ru	ral Route Numb	er, City or Town, Stat	e, Zip Code)
	1 and 2 Health tem 27		Darlene Lawhorn Wife		5416 Price Av				
altimore,	0 0		20a. Method of Disposition 1 ☐ g urial 2 ☐ Cremation 3 ☐ Removal from	State 20b. Place of cemeter	of Disposition (Name of ery, crematory or other pla	ce)	Date	20c. Location - City	
Ħ		1	4 □ Donation 5 □ Other (Specify) 21. Signature of □ real Service Licensee		King Memorial I		02/23/08	Wind	sor Mill, Md.
Ba	permit. Departi Importa any Inj once,		21. Signature of America Service Licensee		Estep	Brothers Fun	eral Service	e, P. A.	
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5	s afte al Dir	Certification:	4 Hottilide Dulid	ng, etc. (Specny)			City of To	wn, state)	
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	o the vithin of the complex co	Med	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (M	fonth, Day, Year)
			JAnh Enl	elt	R	25 000		02/2	0/08
			30. Name and address of person who completed cause Ardalan Enkeshafir	se of death (Item 23a)	(Type, Print) h raven ben	leverd,	paltin		
÷	Sta		31. Date filed (Month, Day, Year) 32.	gistrar's Signature	P-10.				
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				For State Registrar	State of M	laryland		irtment of tificate o				ene g. No.	08	05642	
		Physici		1. Decedent's Name (First, Middle, L Robert A. Lambe		-				ļ	2. Date of Death Month February	Day	Ž008	3. Time of Death 8:00 AM	
		/Medic Examin	0.00	4a. Facility Name (If not institution, g	ve street and number	·)		4b. City, Town				4c. Cour	nty of Death		
		Funeral Director				ge (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Da	ar If Unde	Min.	8. Date of Birth 11/18/19	914	9. Birthp	lace (State or Foreign try) achusetts	
	inder .	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		-1			1	0d. Inside City Limits	
		death with the Maryland ms 23a or 28a-f show	ector	MD Baltime	ore	Parl	kville	10f. Zip Cod	le .		10	a. Citizen o	of What Cour	1 □Yes 2 No	_
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2 should be filed within 72 hours after dea and Manial Hygiene. In marked other then "naturat", or items aumstic event, the Mudical Examiner ma	ges 1 and 2 should be filed within 72 hours after death with the Maryle tof Heath and Marial Hygiens to the establish and Marial Hygiens "natural", or items 23e or 28e1 shou if item 27 ie marked other then "natural", or items 23e or 28e1 shou or other traumatic event, the Marical Examiner must be mailified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2□ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	? X No	1	Vas Decedent fYes, specify C I ☐ Yes 2XX	Suban, Mexic	an, Puerto F	offy Yes or No- lican, etc.)		lace - Americ lack, White, c <i>ity:</i> Whi	etc.		
21215-0036 ad within 72 hours att glane. The water than "natural; or or then "natural; or it the Madical Exercit			Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Deced (Give life. L	lent's Usual Ockind of work do	cupation one during mo tired)	ost of workin	g 1	16b. Kind of	Business/in	Justry	
$\bar{\alpha}$	1212	iled with tygiene. her the	Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La.	College (1-4or	5+)	Pres	ident	18 Mot	har's Nama	(First, Middle, M		rn Air	Inc.	
	land	uld be fi Aental H rked ot tic ever	To Be	Robert P. Lamber						ence			umoy		
2	Maryland	d 2 shouth and N. 7 ie ma		19a. Informant's Name/Relationship Esther Lambert /			1	•				Route Number, City or Town, State, Zip Code) Parkville, MD 21234			
0	altimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 id eny injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3	Removal from State	_ C	lace of Dispo emetery, cren	sition (Name or natory or other	f place)	Da	ate 2	20c. Locatio	n - City or To	own, State	_
7	Baltir	permit. Pag Department Important: eny injury once.		4 Bornalion S County									Maryland 21204 nc. 1050 York Road		
4		*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										Approximate Interval Between Onset and Death	
	-	Pnysician /Medical Examiner		disease or condition resulting in death)	a Due to (or a	is a consequ	ieuce o	141-	heime	ر اد					
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	rds, P	w requires that the state of th	र्व	Part II. Other significant conditions	contributing to death	but not resi	ulting in the u	nderlying cause	given in Par	rt I.		oacco use c es 2 □ No		he cause of death? pably 4 Minknown	,
Ä	Record	The la	Completed								24a. Was ar autops perform 1 Yes 2	n 24 y ned? 2 No	b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of	,
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<u>_</u>	n of	ding Physician: After this certific funeral director.	on: To	27. Manner of Death 1. Natural 5 Pending	28a. Date of In		ER/Outpatier 28b. Time of Injury	28c.	Injury at Work?	2	28d. Describe ho			77	
obe		death ctor: y the	Certification:	2 Accident investigat 3 Suicide 6 Could no determine	be 28e. Place of I	njury - At ho etc. (Specif	ome, farm, str		1 Yes 2		28f. Location (St. City or Town	reet and Nu n, State)	ımber or Rur	al Route Number,	_
X.		To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the besaminer: On the basis and manner	of examina	wledge, deati tion and/or in	h occurred at the	ne time, date my opinion, d	and place, a leath occurre	and due to the ca	ause(s) and ate and plac	manner as s	tated. o the cause(s)	
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		le		30. Name and address of person when the state of the stat	o completed cause of	f death (Iten	23a) (Type,	Print)			rille M	15 01	234		
		Sta Regist		31. Date filed (Month, Day, Year) FEB 2 5 2008	24	strar's Signa	ture		100)	12/1/20	1 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day 1135 **Physician** 08 Kasheed mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pembridge mber 6. Sex 5020 Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Months Hours 1**☆**M 2□ F Yrs. 04/26/1944 North Carolina Director 63 239-68-1799 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 ☐ No Directo Baltimore Maryland. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. by Funeral 5020 Pembridge Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than, Ring & Seals Elementary/Secondary (0-12) College (1-4or 5+) Machinist 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ollie Alexander ဂ Otis Ryce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 Pembridge Avenue, Baltimore, Maryland 21215
ace of Disposition (Name of Date 20c. Location - City or Town, State LAURA J. Mahalale-El / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) King Mem. Park Ceme. 02/23/2008 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Sourture of Funeral Service Linesee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 29 month **Physician** Dancreatio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trar and Due to (or as a consequence of): the attending physician hed for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0658 94 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Balt MD 21215 2401 elde andor

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 9:24 Elizabeth Mary Miles Ам February 22,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 640 Middlesex Rd. Baltimore Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F 165 20 6003 80 Director Sept.13,1927 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21221 USA 640 Middlesex Rd. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental Hiltem 27 is marked ott Be Elizabeth Pope George Donald Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Elizabeth Green (Daughter) 640 Middlesex Rd. Baltimore, Maryland 21221 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages.
Department of H
Important: If Ite
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 2/23/2008 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Stanature of Europed Service Liganic 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final dise e or condition resulting in death) Cancer Physician mont /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Dav Year 5 Other (specify) signed by the a d be detached f I Ves 2 DNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 res 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an this certificate has ral director, page 2 autopsy performe 1☐ Yes 2 No Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No ٩ funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

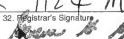
State Registrar

31. Date filed (Month, Day, Year) EB 2 5

30. Name and address of person who comp

John

29b. Signature and title of certifier



eted cause of death (item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Ave, Baltimore MD2/22)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 23 2008 **Physician** 6:32PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA HOSPITAL Baltimore Baltimore (it SINAI 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 MARVLAN 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🕱 F 22-05 LANL Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medit at Examiner must be notified at 1 ✓Yes 2 No Director MARYLAND Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) mentary/Secondary (0-12) College (1-4or 5+) DWN THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (MN - CINKNOWN) Be LLE OBER 4GNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAROL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ROWNSVILLE 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Scensee acardene MD 2121 on1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, of reart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFARCTION myo car dial I m ediate Cause (Final Lease or condition r sulting in death) **Physician** /Medical Due to (or as a consequence of): Heart **Examiner** A theroscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) s been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pertension 2 No 3 Probably 4 Donknown Completed Dependent Diabetes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manual of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURKE, JAMD Hospila SINAI MEDERIC 32. Regarar's Signature 31. Date filed (Month, Day, Year) FEB25 Registrar

DHMH 17 Rev 1/2001

MooR

08-01159 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert A. Muse State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day February 9, 2008 Medical Examiner Allen Robert Muse 4a. Facility Name (if not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death 345 Marydell Road Raltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Foreign Director 212-34-1636 1 X M 2 F 71 5-27-1936 Country) Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Baltimore Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 345 Marydell Road 21229 US Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes Specify: Black If Yes, Give Yeer 3 Widowed 4 Divorced Yes 2 X No specify: other than "natural", ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Al Packer Lincoln 21215-0036 10th Auto Mechanic
118.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Eugene Muse Mary Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m QW W Gwendolyn Muse-Sister 247 Ballou Court Balto, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition : If i crematory or other place) 1 Burial 2 X Cremation 3 Removal from State tant: 2-23-08 Greenmount Cem Baltimore, MD Danation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H 1101 E North Avenue Balto P it I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** foliure. List only one cause on each line. /Medical a. Atherosclerotic Cardiovascular Disease ~xaminer or andition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? Yes 2 ✔ No death? Yes 25. Was case referred to medical 26.Place of Death (Check only one)

05646

MD

21202

MD

Day

Approximate Interval

Between Onset and

Death

Year

2 No

10d. Inside City Limits

1 Yes 2 No

3. Time of Death

1730 hrs

Hospital or Attending Physician: Be of Vital Hospital: examiner? Other; Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division Yes 2 No within 24 hours after death To the Funeral Director: Pendina 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) incontin iD. O.C.M.E. February 10, 2008 K) anna My 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 32. Fraistiar's Signature 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 0459 MURRAY FEBRUARY RONALD 23, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 213-68-3058 1 XM 2 □ F Months 49 29,1958 Director July Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD N/A Baltimore XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1621 N. Milton Avenue 21213 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ŽQNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black þ 3 ☐ Widowed ♣☐ Pivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Machinist National Wire 7. Father's Name (First, Middle, Last) Charles O. Murray, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Rosetta Brown ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5014 Corley Rd. Apt.A4 Baltimore, MD 21207 Ronald Murray, Jr./ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/28/08 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Dames 4210 Belair Rd. Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS MULTI-ORGAN SYSTEM /Medical Due to (or as a consequence of): **Examiner** DAYS HYPOTENSIVE HEMORRHAGIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence oil Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and GASTROPATHY YEARS PORTAL Due to (or as a consequence of): attending physician Physician/Medical 15 YEARS CIRRHOSIS HEPATTIC IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 o 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25 No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3□ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Expertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 FEBRUARY 23,2008

State Registrar CHRISTOPHER

31. Date filed (Month, Day, Year) FEB 2 5 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

KANAKRY MD, THE JOHNS HOPKINS HOSPITAL, GOO NOATH WOLFE STREET, BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

05648

	1 - State amend	#20b&c	PER FH G8	11 3/26	ertificate	e of De	eath		Reg. No.			
Dhusisian	Decedent's Name (Fit							2. Date of D Month	eath Day	Year	3. Time of 03 4	
Physician /Medical	MICHAE	L			MCK1			02	20	2008	034	M
Examiner	4e. Facility Name (If not						cation of Deat		4c. Co	unty of Death		
	THE JOHN 5. Social Security Number			In yrs. last birtho			10RE Under 24 Hrs	8. Date of Bi	rth .	O. Disti	lace (State o	r Foreian
Funeral Director	217-15-015		2 □ F	49 Yr	Months		lours Min.		19,19	958 Ma	lece (State o itry) rylar	ıd
	Usual Residence of Dec										0d. Inside Cit	
with the Maryland or 28a-fahow be nutified at Director	MD 10a. State	N/A		0c. City, Town o	Baltin	ore					XXYes	
	10e. Street and Number 2703 OSW6		ıue		10f. Zip	Code 212	15		10g. Citizer	of What Cour USA	ntry?	
death death sme 23	11. Marital Status	12.	Was Decedent Ev Armed Forces?	er in U.S.	13. Was Deced	ent of Hispa	inic Origin? (S Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14.	Race - Americ Black, White,		
33. s s s	1XX ever Married 3 Widowed 4		1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2		ipecify:			Specify: Black		
5-0 72 hc	15. (Specify of	Decedent's Educat	ion ompleted)	(0	ecedent's Usua Bive kind of wor	k done durir	n ng most of wo	rking		of Business/Inc	-	
21215-00 ed within 72 hou ygiene er than "natura.i., the Madical Completed	Elementary/Secondar 10th Grad	y (0-12)	College (1-4or 5+)		fe. DO NOT us T.a	ibore:	r			ey's T val Se		چ
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yland yland yland wuld be fil Mental H strked ott	Charles N	Norris						Hopewe.				
Maryland 21215- and 2 should be filed within 72 is the advental Hygiene 27 is marked other than "nate recomments event, the Margies To Be Complete	19a. Informant's Name/ Phyllis M	Relationship (Type Manley/	Print) Friend	19b. N 270	failing Address 3 OSW€	(Street and	Number or R. Venue	Balti	oer, City or To nore,	wm, State, Zip Maryl	and 2	21215
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic events. To E	20a. Method of Disposition 1 XBurial 2 Cr 4 Donation 5 C	emation 3 Rem	noval from State	20b. Place of D Milemete/ King M	isposition (Nem LOME to CIN CMOT 13	atery 1 Pa	3/15 rk 3/	1/08	Balti Randa	nore, M	wn, State	1D
nit. P nit. P artme ortan injury	21. Signature of Funera				22. Name an	d Address o		natman.	-Harr	is Fun	eral	Home
B Ped ming	Sero	in Ala	ساريا					wn Rd.				
	23a. Part1. Enter the di shock or heart fai	sease, or complica fure. List only one	tions that caused th	e death. Do no	enter the mod	e of dying, s	uch as cardia	c or respiratory	arrest,		Approximate Interval Bett Onset and I	ween
Physician	Immediate Cause (Fina			TOLIC	CAR	DIA	CAR	REST			Onset and t	Jeatn
/Medical Examiner	resulting in death)		Due to (or as a	consequence of)	:						IDA	. ~
	Sequentially list condition	ons, b	Due to (or as a	DAC CONSEQUENCE Of		EM11	4			-	()/1	- 1
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60, be executed ician and burial-transit												
		d	SYSTEMIC INFLAMMATORY RESPONSE SYNDROME 2 DAY							75		
K 6876 entificate be ling physicia e as the bu	IF FEMALE:											
	23b. Was decedent pre- in the past 12 mon	griant	If yes, outcome of 1 Live birth 2	Fetal death	3 DEctopic pr				23d. Date of delivery Month Day Year			Year
. 0 60	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4☐Pregnant at tir 9☐ Unknown	ne or death	5 Other (sp.	өспу)						
P.O. that the ted by the detache	Part II. Dther significan	t conditions contri	buting to death but	not resulting in t	ne underlying c	ause given ii	n Part I.	23e. Did	tobacco use	contribute to t	he cause of c	death?
rds, n sign ad by	HUMAN	JIMM	INODEF	FICIEN	CYV	IRUS	5	1 🗆	Yes 200	o 3□Prot	ably 4 □l	Jnknown
Vital Records, sicien: The law requires the certificate has been signe irector, page 2 should be completed by								24a. Wa	s an 2	24b. Were auto	psy findings mpletion of c	available ause of
The lav								per 1 ☐ Yes	formed?	death? 1 ☐ Yes	2KINO	
Vital Ricien: The certificate rector, pag	25. Was case referred to examiner?						3. Place of De	ath (Check only	one)			
F & Signature	1 ☐ Yes 📆 No		pital: Inpatient					Home 5 Res			<i>y</i>)	
ding Ph After th funeral			28a. Date of Injury (Month, Day)	(ear) 28b. Tin	ne of 2	8c. Injury at Work?	2 □ No	28d. Describe	now injury o	ccurred		
Division of Vital or Attending Physicien: after death. Director: After this certification; In by the funeral director, I be the funeral director di	2 Accident 3 Suicide 6	investigation Could not be	28e. Place of Injury	r - At home, farm				28f. Location	(Street and N	lumber or Rura	al Route Num	nber,
Div Blor A safter Ni Dira	4 Homicide	determined	building, etc.	(Specify)				City or To	own, State)			
Division C To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification;	29a. Certifier 1 (Check only 2 one)	Certifying Physic Medical Examine	ian: To the best of c: On the basis of e and manner state	xamination and/	death occurred or investigation,	at the time, in my opini	date and plac on, death occ	e, and due to the urred at the time	e cause(s) an , date and pl	nd manner as s ace, and due to	tated. the cause(s	5)
Fo the complete of the complet	29b. Signature and title	of certifier				License nu				igned (Month,		
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1	30. Name and address											
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Physician /Medical Examiner

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After or Attending

after death Director;

24 hours To the Funeral þ

Completed

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Certification:

Medical

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

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10a. State

Funeral

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"natural", or items 23a or 28a-f show edical Examiner must be notified at

nd Mental Hygiene. marked other than

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Pages 1 and 2 should be nent of Health and Mental

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Cequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician hed for use as the buria Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1- Inpatient

		0 . 1000	~.,	Pom	
Was an autopsy performed?	24b.	Were autops prior to comp death?	sy find pletior	lings ava	ailable se of

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death 1. Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

26. Place of Death (Check only one)

6 ☐ Could not be determined 3 Suicide 4 ☐ Homicide

1 TYes 2 TNo Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

S. GREENE

29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) and ad

29d. Date signed (Month, Day, Year) 08

10 State

Registrar

TUBALLY
32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 5 2008

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Margaret Mary Moran 8:00 AM February 22, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 86 Director 215-18-9710 22,1921 Maryland Sept. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b, County show 1 Yes 2 No r 28a-f sh notified Directo Maryland Carrol1 Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ral", or items 23a or Examiner must be r 21784 504 Hawkridge Lane USA Completed by Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 3 XWidowed 4 ☐ Divorced "natural" er than "nature the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic even Agnes Powers Daniel P. Worthington ۵ f Health and N tem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7605 Ridge Road; Marriottsville, MD 21104 Brian Moran Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott 2/25/2008 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Se Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 1 Yes 2 3 Ectopic pregnancy Month Day Year menths? 5 ☐ Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) rthis c τIdire 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Certification: (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) YC s of person who con e Red Ste いっからい 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB25 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:07 PM /Medical 4c. County of Death . City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KALTINOR -/IMORE 1 Year | If Unde Date of Birth (Month, Day, Year) vrs. last birthday **Funeral** Months Days Hours Min 1 4 2 F Director rainia Usual Residence of Decedent death with the Maryland Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ⊈es 2 No Funeral Director MD timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Was Decedent Ever in U.S Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4or 5+) wne Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event, <u>theore.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship to.MD 21239 Baltimore. 20b. Place of Disposition Pages 1 Burial 2 Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ye to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the the attending IF FEMALE: use. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed? certificate 2□ No 1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No npatient 3 ☐ DOA 1 ☐ Yes 2 ER/Outpatient 2 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After (Month, Day Natural 5 Pending investigation 1 ∏ Yes 2 ∏ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) FEB 2 5 2008

30. Name and address of person who completed cause of

32. Registrar's Signature

nature

MOATI

08-01445 James M. Mays

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ledical Exami	ner		M. Mays					F	Month ebruary	19, 2008	Year 3	1258 hrs
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*		Usual Residence of Decedent			4							
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876 tificat ng phy	[]	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ne of pregnar		aldeath 3	Ectopic	c pregnancy	,		Date of deliver onth	ry Day Year
X 6	<u>i</u>	past 12 months?	4 Pregnant at	time of death		ner (Specify)		p. eg. e.,	,	- 1		
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₽ <u>₹</u> ₹ 8	Me	29b. Signature and title of certifie	and manner stated.			29c. Licer	se number			29d. Da	ite signed (Mi	onth, Day, Year)
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	ŀ	30. Name and address of person		eath (Item 23	(a)							
(11)		Donna M. Vincenti, M		•	•	Penn Stree	t, Baltime	ore, MD	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 7.45PM **Physician** Fe burary 15 2008 Kenneth M. Nunnally /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore, MD N/A Saint Agres Huspital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Sex M 2□F 5. Social Security Number **Funeral** Days Hours Vrs 1953 Germany Director 218-60-8043 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 1 Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 903 Brunswick St. "natural", or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. White 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 □ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A (Disabled) N/A 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Stocksdale Travis B. Nunnally, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3025 Arizona Ave. Baltimore, MD. 21234 19a. Informant's Name/Relationship (Type. Print) 3025 Arizona Ave. Mary Jane Heck, sister 20b. Place of Disposition (Name of Westers Victorial Professional Victorial 20c. Location - City or Town, State Odenton, MD 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 2A Nor and Address Heren Home, Inc. 21227 Arbutus, MD. Erena 1328 Sulphur Spring Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metabolic 1047 aci disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 Year Cardiomy oputh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner years burial-transi End Stage rg P Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Year Por in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at Id be detached fo 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been s page 2 should Completed Renal Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 2 No P No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Impatient Inpatient 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Nunnally, Kenneth

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, page

27. Manner of Death Natural 5 Pending investigation

2 Accident

(Check only one)

29a. Certifier

6 Could not be determined 3 ☐ Suicide 4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier M WIVE MD

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD TARIQ 31. Date filed (Month, Day, Year)

900

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Caton Avenue Baltimore MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Certification:

Medical

FEB 2 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 98/6 2-25-08 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:45 P^M 02 20 2008 Elizabeth Jean Ningard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11216 Beach Road White Marsh Under 1 Year | If Under Baltimore 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 1 □ M 2**X**) F Director 06/09/1936 214-34-4081 Maryland the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 X No Examiner must be notified Funeral Director MD Baltimore White Marsh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 11218 Beach Road 21162 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed Item 27 is marked other than "natu other traumatic event, the Mental 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver Schools 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 James Bridges ပ္ Mildred Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Ann Gibbs (daughter) 11216 Beach Road - White Marsh, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If It 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/26/2008 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses É ana 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatio bmonth ung cance /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has certificate ha autopsy performe funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be daughter s Hospital: 1 ☐ Inpatient 21**2**(No Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA residence 27. Manner of Death

1/X Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury s after oc. ral Director: An 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SWASALUAM, Suite 208, 9114 Philadel phia soud, Baltimore MD21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

112A beth

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** INTHIA 00 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months 54 APRIL 29, 1953 TX Director 455.06.5980 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes XX No Director MD QUEEN ANNE QUEENSTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 111 SOMERSET COURT 21658 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giv 14. Race - American Indian, 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married 1 □ Yes XX No WHITE Specify: Specify: ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME MAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORA KNOTTS WAYNE ROSE or other traumatic ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau HUSBAND 111 SOMERSET COURT QUEENSTOWN, MD 21658 CHARELS ANTHONY OCDEN 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition LAUREL OAKS MEMORIAL ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2.25.2008 MESQUITE, TX RARK 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT
426 CRAIN HMY S. GLEN BURNIE, ND 21061 21. Signature of Funeral Service Licens K. GREORY FINE M01148 Approximate Interval Between Onset and Death Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Quse (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the attending esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year for 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed Yes 2 certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ D0A 1 Inpatient 2 ER/Outpatient 1 ☐ Yes Medical Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury Injury (Month, Day Year) the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide n 24 hours aft **je Funeral Di** bletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my colored death accurred. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 2 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) CANTER 800 BESTEMERD, MNAPULIS, MD 2140 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 11:25 AMM 2008 Paul Eugene Oberdorf February 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16809 Cashell Rd. Olney Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M M 2 □ F Director 61 11/06/1946 PA 177-40-3226 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Olney MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 20832-United States 16809 Cashell Rd death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1⊠Yes 2□No IfYes, Give Vietnam 1 Never Married 2 Married Maryland 21215-0036 1 □ Ŷes 2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Computer Technology Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Computer Engineer other ! other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Pages 1 and 2 should be ပ္ Clarence M. Oberdorf Helen E. Michadick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Veronica A. Oberdorf/Wife 16809 Cashell Rd. Olney, MD 20832-Department of Heal Important: If Item 2 any injury or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 1 Burial 2 ☐ Cremation 3 DR Removal from State 4 □ Donation 5 □ Other (Specify) Gilpin Township, PA St. Catherine's Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00382 Stisled Lohi Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** reutztiela /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to Escas a consequence off Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 5 Other (specify) P.0. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 2 No Division or Vital 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred spital or Attending Phours after death.
Ineral Director: After ty filled in by the funera 28c. Injury at Work? (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and mapmer stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08

DHMH 17 Rev 1/2001

State

Registrar

MUNICIPSIER MILL RD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHENENIEVE WROBLEWSKI

2008

31. Date filed (Month, Day, Year)

FEB 25

MD

32. Registrar's Signature

08-01568 Cornel G. Peterson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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offiel G. Peterso	1.	For State Of Maryland / Department of Fleath and Works	Reg.	AU U	00000
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledical Examin		Cornel G. Teterson	Month D February 23		2350 hrs
J.) .	_	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D	Death	4c. County of Dea	th
		University of Maryland Baltimore		NA	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	AHrs. 8. Date of Birth(MM/DD/YYYY) 9. B Fore	irthplace (State or ign Hany and ountry)
Director		219-56-6392 17 M 2 F 55 Yrs. Months Days Hours	Aug 23	1952 0	ountry) 7 and
	Ţ	Usual Residence of Decedent			10d. Inside City Limits
v any	- 1	10a. State 10b. County 10c. City, Town or Location			1 Yes 2 No
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ne Maryland or 28a-f show fied at once.	ᇎ	10e. Street and Number	Tog	. Citizen of What Co	L
ith the Maryland 23a or 28a-f she notified at once	إ⊵	2118 W. Baltimore 21223	0 / 0 / 1 / 1 / -	U.S.M	erican Indian, Black,
th wit ther		11. Marital Status 12. Was Decedent Ever in U.S. 1Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 11. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	sticali ilidiali, biack,
r deat	ᇍ	Yes 2 No		Specify: 3	ack.
s afte	ਙੈ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin	nd of work done	6b. Kind of Busines	
hour "nate	뒽	Elementary/Secondary (0-12) College (1-4 or 5+)	se retired)		,
36 hin 72 e. than sdical	흷	12 Jaborer	1	Constr	uction
215-0036 se filed within 72 hours after tal Hygiene. ked other than "natural", rint, the Medical Examine.	Completed	17. Father's Name (First, Middle, Last) 18.Mother's	Name (First, Middle, Ma		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medice	Be	Donald Referson Juli	a Mallic	off	
21, hould the and Mer is mar		19a Informant's Name/Relationship (Type, Print)	er or Rural Route Numb		ate, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	L	Ray Collins Sister >901 Edgewood k	d. apt 123	20c. Location - City	/ •
re, I and I Heal f item		20a. Metrod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Removal from State	_		
More Pages 1 ent of F int: If i		4 Donation 5 Other Specify: King Mem Park	Feb 29,2008	134/to.	red-
Baltimore, permit. Pages I an Department of Het Important: If ite Important in ite injury or other tr	Ī	21. A nature of Funeral Service Licensee 22. Name and Address of Family	glass Fune	ral Servi	ce PA-
O FOFFE		(autoten C. K) Muleus 1701 Mc Cullock	St. 1591d	· Ma.	Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	diac or respiratory arres	st, Shock, of Heart	Between Onset and Death
vaminer	1	Immediate Cause (Final disease a. Multiple Injuries			
		or condition resulting in death) Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
,	튑	cause. Enter Underlying Cause (Disease or injury that initiated			
Pa isi	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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60, ate be e shysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	very
876 tifficat ng ph		23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	Month	Day Year
X 6 th cer trendi	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Bo le dea the a	Physician/	1 Yes 2 No 9 Unknown g Unknown	t 23e Did tol	pacco use contribute	to the cause of death?
.O. that the	P P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par			Probably 4 Unknown
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al Fian:	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other			
Vit Inysic	٥	1 V Yes 2 No		Residence 6 O	ther:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		1 Noticel 2215 hrs 2215 hrs	Pedestrian s	truck by auto	
Sion Attend death. ector:	äţi	2 Accident September 23, 2008 2210 113 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		treet and Number of	Rural Route Number, City
JVIS I or A after I Dire	Certification:	Suicide Could not be	or town, St		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide (System) Edital Street			
he Ho in 24 he Fu pletel	ical	20a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat (Check only one) Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occ	curred at the time, date	and place, and due t	o the cause(s)
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed	
		his his, mo O.C.M.E.		February 24,	2008
		30. Name and address of person who completed cause of death (Item 23a)		<u> </u>	
1		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
St	ate	4			
Regist		TED 9 5 700X Mathematical April 1980			

08-01449 Ge

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George Petrovich		1- For State	Stat	e of Maryla		ertificate d		and Mer	ntal Hygie		21	JUE	U555
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Medical Examin		GEOR(nive street and nu		OVICH	4b City Tox	vn, or Location		bruary 1	9, 2008 4c. County of	Death	1445 hrs
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Funeral		5. Social Security N		. Sex	7. Age (In yrs	. last birthday)	If Under			Date of Birth	h(MM/DD/YYYY)	g. Birthp Foreign	lace (State or
Director	Į	221-52-3	1.	M 2 F	4	9 Y	Months rs.	Days Hour	s Min. 1	1-9-	1958	Coun	^{lry)} PA
any	ŀ	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Loc	ation	_				1	0d. Inside City Limits
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Maryla 28a-f	Director	10e. Street and Nur		2 2022			10f. Zip Ci			10	g. Citizen of Wha		/?
1625 death with the Maryland or items 23a or 28a-fah must be notified at once		77 ZION	ACRE				21901		U.S.A.				
ath wit	uneral	11. Marital Status 1 Never Marrie	ed 2 X Mam	ied Armed Fo	edent Ever in	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - White,		n Indian, Black,
fler de	<u>ш</u> [3 Widowed		1 Yes		2X No 1 Yes 2 X No specify:					Specify: WHITE		
natura Xamir	ed by				only highest grade completed) 16a. Decedent's			it's Usual Occupation (Give kind of work done ost of working life. DO NOT use retired)			16b. Kind of Business/Industry		
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5-0036 iled within 7: Hygiene. I other than the Medical	Com	12 17. Father's Name (First, Middle, L					er's Name (First	l, Middle, M	ACME MARKETS Middle, Maiden Surname)			
1215 be file mtal H irked o	Be	GEORGE			roVi				ROTHY		(NOE		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na LINDA PE									•		10
e, M and 2 Health item 2 traun		20a. Method of Disp			20b. Place of Disposition (Name of cemetery,					D NORTHEAST, MD 21 Date 20c. Location - City or Town, State			
Baltimore, permit. Pages 1 a Department of He Important: If it	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: ALL SAINTS CEMETERY 2-2.								5-08	WTT.MT	NGT	ON DE	
altir	1	21. Signature of Fu				22	. Name and Ad	ddress of Facili	ty CVACI	I/ROS	SEDALE	FUN	ERAL HOME
	4	23a. Part I. Enter th	\sim				211 CI	HESACO	AVE	ROS	SEDALE,	MD	21237 Approximate Interval
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Division tal or Attendi rs after death. al Director: /	ertification:	2 Accident 3 Suicide	Investi 6 Could	gation 280 Place	e of Injury - At	t home, farm, st	reet, factory, c	office building,				er or Rura	Route Number, City
Divisi pital or At ours after d neral Direct filled in by	Certi	4 Homicide	determ							or Town, S	State)		
2 d = 2		29a. Certifier 1 (Check only one)	Certifying Phy	sician: To the besiner:On the basis	t of my knowle	edge, death occ	curred at the ti	me, date and p	place, and due	to the caus	e(s) and manner	as stated	f. cause(s)
To the within To the comple	Medical	29b. Signature and		and manners	tated.			License numbe		.,	29d. Date signe		
		Samuel	Fralle.	11 nul			O.C.M.E.				February 20	0, 2008	3
1		30. Name and addr		•								·	
Ø		Pamela E. S		_				Street, Balti	more, MD 2	21201			
Sta	ate	31. Date filed (Mont	n, Day Year)	2008	egistrar's Sign	aure	Charles .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Alice Virginia Percy 02/13/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Home Catonsville Baltimore 8. Date of Birth Nov. 10, 1930 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 77 Yrs. **Funeral** Months 1 □ M 2 1 F 213-28-7814 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Director Halethorpe 10g. Citizen of What Country? Street and Number 10f. Zip Code 1806 Mayfield Ave. 21227 **USA** Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. ģ 3 Widowed 4 Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Activity Director Health Care permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 Is marked other any Injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Crawford Percy Virginia Dean 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6227 Oak Hill Dr. Sykesville. MD. 21784 19a Informant's Name/Relationship (Type. Print) Nancy Corbitt, cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 02-16-08 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Eurperal Service Licensee Ambrose funeral Home, Inc. repleo 1328 Sulphur Spring Rd. 21227 Arbutus, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to r as a conse vience of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 No detached 9□Unknown 9 Unknown ò signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 2 No ON AS 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide determined 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific Marchen Choice lane, bald 2120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 29c, perDVR, g876, 2/25/08 The Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Posey homas, E 2 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maylans Medical Center

5. Social Security Number | 6. Sex | 7. Ag 22 S. Green St er 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 20, 1955Washington, DC 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 52 218-66-5261 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County Maryland Howard Director Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9524 Old Lantern Way 20723 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Š 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Painting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Effie M. Gordon Thomas Edward Posey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9524 Old Lantern Way, Laurel, Maryland 20723 Mary J. Posey Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Baltimore, Maryland 4 □ Donation Metro Crematory Inc. 02/21/2008 22. Name and Address of Facility
Witzke Funeral Home, Inc. 21. Signature of Funeral Service Licenses MUI283 5555 Twin Knolls Road, Columbia, Maryland 21045 or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failur. Immediate Cause (Final disease or condition resulting in death) **Physician** Melanoma, metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 2 No To the Hospital or Attending Physician; 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☑ No death. after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DZ:30M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

3005, OS

White

1 ☐Yes 2√2 No

State Registrar 31. Date filed (Month, Day, Year)

25

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1+ more

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 20 per verb., g8/6,02/25/08dhb Reg. No. 0566 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 15°2008 6:000R Palombo Bernadine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Baltimore Baltimore County 6701 Highview Avenue 8. Date of Birth (Month, Day, July 12 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min , *Day, Year)* 12, 1930 1 □ M 2 □ F Baltimore, Maryland 77 217 24 7680 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d, Inside City Limits 10a. State 10h. County or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 X No Director Baltimore Baltimore County Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code LISA 21206 6701 Highview Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: Be Completed by 3 X Widowed 4 ☐ Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Railroad Office Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental h Mary Fousek Edward Steiner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21206 5806 Comstock Avenue Health a Delores Brockman (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or Metro Crematory Inc February 18 2008 Baltimore.Marvland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 300 7401 Relair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OPT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uncase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68/760 Physician/Medical as IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknow þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performe 1∐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 5 Pending investigation Jepital or .
4 hours after dea..
raal Director; A'
by the 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Chec To th. within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur completed cause of death (Item 23a) (Type, Print) 30. Nam EAST EAGER ST BANTONE UN 21202

State Registrar GUNE

31. Date filed (Month, Day, Year)

FEB25

2008

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Physician Pilachowski Joseph February 21, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, **Funeral** Year 1 X M 2 □ F Sept17,1927 Maryland 220-20-0174 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Anne's Oueen Stevensville 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21666-3224 U.S.A. 118 Laird Benton Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Xes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 21215-003⁶ 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Draftsman Thompson Industries 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Joseph F. Pilachowski Anna G. Walczuk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9033 Naygall Road Baltimore, Md. 21234 Joseph R. Urbanski(nephew) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-25-2008 Baltimore, Maryland Holy Rosary Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilityaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Robert 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on what line. Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical **Examiner** Dequentions list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Hospital: 3□ DOA 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient ဥ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Certification: 5 ☐ Pending within 24 hours are: Co. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5+1 State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

32. gistrar's Signature

, nozwo7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 8:00 20 08 Maria Teresa Parcells /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson, Mary Lanu

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore Co. Gilchrist Hospice Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 88 347-12-6227 Chicago, IL Director 9-14-1919 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ä 1 ☐ Yes 2. No 28a-f sh notified **Funeral Director** Columbia MD Howard Co 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or items 23a or Medical Examiner must be r 5400 Vantage Point Rd HC419 21044 14. Race - American Indian, death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 1 Yes 2 □ No Specify: Mexican Specify: Completed by 3 Widowed 4 ☐ Divorced Hispanic 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) aith and Mental Hygiene. 27 is marked other than "i r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12 Musician Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jose Castro-Leon ပ Maria Sanchez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any Injury or other trau Julie Parcells/daughter 4706 Woodland rd. Fllicott City, MD 21042 e of Disposition (Name of Date 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 2/22/08 Beltsvil
22. Name and Address of Facility
Cremetion and Funeral Alternatives.
8717 Green Pastures Dr., Towson, M 2/22/08 Beltsville. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOIYEZ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementa 42003 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical aftending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performe 1□ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 1 Yes 2 No Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

the Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours after death.

ne Funeral Director; A

oletely filled in by the fu within 24 ho

To the Function

completely 1

6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 21 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN MO MO Charles ST 6701 MA

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death FEBRUARYDay 22 2008 **Physician** RAHLEY HARRY CARROLL Jr. 1:06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL ROSEDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 04 / 1942 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2 □ F MARYLAND 212-40-0792 65 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 XNo BALTIMORE ROSEDALE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2338 HAMILTOWNE CIRCLE 21237 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: VIETNAM 1 Never Married Married 0 Specify: WHITE 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UTILITIES ENGINEER BALTO. 12 0 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental HARRY C. RAHLEY POPP SR. EVELYN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ANN GRZECHOWIAK RAHLEY/WIFE 2338 HAMILTOWNE CIRCLE ROSEDALE, MD 21237 of Health item 27 i permit. Pages 1 a
Department of Her
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART JESUS 2/26/08 DUNDALK, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME License 21. Signature MD 21237 1211 CHESACO AVE BALTIMORE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER disease or condition resulting in death)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed and burial-tra attending physician

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Sequentially list conditions

use as the for page 2 should be director,

signed by

certificate has Physician: The

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4 hours after death. Funeral Director; /

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filled in by

or Attending

Division or Vital Records, P.O.

if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE HYPERTENSION DIABETES MELLITUS 25. Was case referred to medical examiner? 1 ☐ Yes 2X No 1 ☐ Inpatient 2 X ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 1 XNatural Injury 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, of building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Due to (or as a consequence of):

Due to (or as a consequence of):

LIVER METASTASIS

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Jnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 2 XNo

26. Place of Dea	un (Check only one)
Other: 4 \sum Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

one)	and manner stated.
29b. Signature and title of certifier	1
1 attan	asir M

29c. License number
\$\int -2890 \cap \]

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD ATTANASIO 9000 FRANKLIN SQUARE DR. BALTO.. MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per dr., g876 62425408dhbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Carl M. Roberts FEBRUARY 13, 2008 7:30A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Nursing Home Boonsboro Washington 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1X M 2 ☐ F 82 215-20-9707 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at Director 1 ☐ Yes 2 No MD Washingto Boonsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 141 S. Main Street 21713 USA items 23a Funeral within 72 hours after death unk | 12. Was Decedent Ever in U.S. Armed Forces?
arried | 1 ∑ Yes 2 □ No | If Yes, Give | Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò, 1 ☐ Yes 2 🕅 No þ Specify: 3 Widowed 4 Divorced white "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk MM : ROBETS (Baltimore, Maryland 2121 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) the unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk 1 and 2 should be Health and Mental ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permii. Pages 1 and 2 Depa ment of Health a Impo ant: If item 27 is any injury or other trau Reeders Nursing Home 141 S. Main Street Boonsboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wades 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 b, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, heart failur Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAU **Physician** CANCER moneen /Medical Due to (or as a consequence of): Examiner DEMENTIA month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed neuwonea attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar 29b. Signature and title of certifie

FEB 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 02.13.2008

GHAZALA QADIR e filed (Month, Day, Year)

Orda

LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 29311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10f per fh 9876 2-25-08 vt. State of Maryland Poepartment of Health and Mental Hygien 1- State Registrar Amend 28b, per ME, g876, 2/25/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2008 05:08 AM Demetrick Reese Feb /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boutmore ato Johnstopkins Boyview Med. Ctr. Baltimore Lite 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 22 Yrs. 8. Date of Birth (Month, Day, NOV- 2 If Under 1 Year 5. Social Security Number **Funeral** 1 M 2 ☐ F Days Hours Min 215-11-8033 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Marian Exercities the rediffied anone. 10a. State 10b. County 1 Nes 2 No Baltimore Baltimore Citi Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 1420 Hilton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BIOCK Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Holley Wanda James Killse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tames J. Reese, Jr 1420 N. Milton Lenne Balto, MD - Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD Memorial 2-23-2008 Park 22. Name and Address of Facility March East 1-1 H. 21. Signature of Funeral Service Licensee Balto, MD 21202 101E. North Avenue w ane a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CRESpiratory tallure, 3day5 **Physician** /Medical Due to (or as a consequence of) Examiner 15daus TBSA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical JANA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 √ res 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of Injury unk 28a. Date of Injury (Month, Day Year) 28c. Injury Work 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 Natural JAN 29 2008 110+ 1 Yes 2 □ No WINDS 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Pactori Baltimore 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Abachessen 31. Date filed (Month, Day, Year) 32. Reditrar's Signature State FEB 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05667 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month RUSSEU **Physician** 1048 PM J0415E /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 12/19/1928 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 P Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐¥es 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? Street Apt 2123 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HITK Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be ၉ Georgianna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alleu D. Ih Aberdeen, MD 2100 Tralee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Memorial 21. Signature of Funeral Service Licensee C. Greene Funeral Serve ler 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STOMACH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has le 2 autopsy page certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this After thi funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

Registrar

State

NILANTHA

31. Date filed (Month, Day, Year)

FFB25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

CENORA

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland /		artment of F rtificate of				- /	008	05668
			Hegistrar Decedent's Name	e (First, Middle, L	.ast)		007	incate of	Deal	11	2. Date of De	Reg. No. ath		3. Time of Death
18	Physici		CERTRUDE	B REYNOLDS							Month FEBRUARY	Day	Year 2008	0630 A M
100	/Medi Examir				ive street and number)			4b. City, Town, o	r Locatio	n of Death	LDROM	-	nty of Death	
			OAK LODGE	ASSISTED	LIVING			PASADE	NA			ANI	NE ARUN	
	Funeral		5. Social Security N	umber 6.		e (In yrs. last		If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth Con	nplace (State or Foreign untry) MD
	Director		215.07.680 Usual Residence of		1 □ M 2 □ F XX	90	Yrs.				OCTOBEF	ER 24, 1917 ND		
	land ow		10a. State	10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary I-f sh fied a	ţō	MD	ANNE ARU	NDFL	PASADE	NA							1 ☐ Yes 2☐ No
	or 282	Director	10e. Street and Nur			11107102		10f. Zip Code				10g. Citizen o	of What Co	
	th wil	a E	7755 OU	TING AVE.				21122					USA	
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces? 1 Yes 201	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cub	lispanic (an, Mexic	Origin? (Spe	cify Yes or No Rican, etc.)	- 14. R	ace - Amer	rican Indian, a. etc.
36	s afte	by Ft		ied 2 Married	1 ☐ Yes 🏄 🐧 I If Yes, Give Year or Dates:	No		I∐Yes 2XXNo	Speci			Spe		,,
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	pq p	3 Widowed	15. Decedent's	_	16	la Deced	lent's Usual Occur	nation			16b. Kind of	WHI Business/I	
15	in 72 n "ne Medic	Completed	(Speci	ify only highest g	rade completed) College (1-4or 5		(Give life. L	kind of work done OO NOT use retire	during m d)	ost of worki	ng	Tob. rand or	Duoi i i coo, i	riduotiy
212	d within giene.	ĕ	8	ridary (0-12)	College (1-46)	,	HOME	MAKER				OHN H	ЮМЕ	
bu	be filed Ital Hygi Id other event, t	Be C	17. Father's Name	First, Middle, Las	st)				18. Mo	ther's Name	(First, Middle	Maiden Surn	ame)	
yla	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	ို	ELMER MON	TGOMERY					ИYR	TLE HAR	TLOVE			
Maryland	12 sh h and 7 Is m rraum		19a. Informant's Na	·				g Address (Street				er, City or Tow	vn, State, Z	ip Code)
	ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	. //	MARY C. M 20a. Method of Disp		DAUGH			NI CHOLAS \			MD 21601	20c. Locatio	n - City or 3	Town State
р	Pages nent of I nrt: If ite	4	XX Burial 2	☐Cremation 3	Removal from State			sition (Name of natory or other place	ce)	2.23.2		BROOKLY		iomi, stato
Baltimore,	All Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signard Funeral Service Lifensee 22. Name and Address of Facility FINK FUNERAL HOME, P 426. CRAIN HWY S. CIE						i	000	DROOKLI	ייי אויי				
ñ	permi Depa Impo any Ir once.		KL CREC	CORPORING	Janes	H01148		NK FUNERAL 6 CRAIN HWY			RNIE, MD	21061		
	STEELS				plications that caused yone cause of each lin		o not ent	er the mode of dyir	ng, such	as cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Vuse /	Final		entra								3 Onset and Death
	/Medical		disease or condition resulting in de th)	-	a	a consequenc	e of):							7(0)
8	Examiner	Ļ	Sequentially list cor	nditions,	b									
V	per isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of Injury											
	execu and al-trai	Examiner	that initiated events resulting in death) L		c Due to (or as	a consequenc	e of):							
68760,	e be (siciar	edical E			d									
68	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	ē												
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 □Live birth		ıth 3.□	Ectopic pregnancy	,			1	Date of deli	/
. E	e dea he att	Physician/M	in the past 12 1 Yes 2	Months?	4□Pregnant at 9□Unknown			Other (specify)	, 				Month	Day Year
P.0	ires that the de signed by the a be detached f	Phy	9 Unknown	Miller -	contributing to death be	ut not reculting	in the ur	dorluing gauge give	on in Da	41	220 Did t	obacca usa co	antributa to	the cause of death?
ds,	signe d be d	<u>5</u>	Tait ii. Ouler sigilii	icant conditions	contributing to death b	ut not resulting	in the un	idenying cause giv	en in Fai	t I.	1 🗆			bably 4 □Unknown
Ö	w requir been si should b	Completed									(9			
Rec	he lav e has ge 2 :	ld m									24a. Was auto perfo		prior to c death?	topsy findings available ompletion of cause of
<u>ta</u>			25. Was case refer	red to medical	T				OC DIA	on of Dooth	1□ Yes	2 XX No	1 □ Yes	2□ No
or Vital Records,	Physician: this certific ral director,	To Be	examiner?		Hospital: 1 ☐ inpatie	nt 2 ☐ ER/0	Dutpatien	t 3□ DOA Oth	er.		(Check only only one 5 ☐ Resi		ther /Sec	VSTED LIVING
ō	ding Ph		27. Manner of Death		28a. Date of Inju (Month, Day	ry 28b	. Time of injury	28c. Injur Wor				now injury occ		YSIED LIVING
<u>0</u>		atio	2 Accident	5 Pending investigation	on	, , , , , , , , , , , , , , , , , , , ,	injury		Yes 2	□No				
Division	I or Attending after death, Director: After I in by the funer	Certification:	3□ Suicide 4□Homicide	6 ☐ Could not l determine	28e. Place of inju- building, etc	ary - At home, c. <i>(Specify)</i>	farm, stre	eet, factory, office		2	8f. Location (a City or To	Street and Nui vn, State)	mber or Ru	ral Route Number,
	Tothe Rospital or Attent within Et hours after death To the Funeral Director: completely filled in by the		29a. Certifier	(XXX)	thusialan Tathaha	af amulus and a								
	Fun Fun etely i	Medical		2 Medical Exa	hysician: To the best of the basis of aminer: On the basis of and manner sta	examination i	ge, deatr and/or inv	estigation, in my c	me, date opinion, d	and place, a leath occurre	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	vithin romple	Me	29b. Signature and	litle of certifier	- // /	1_		29c. Licens	e numbe	r .		29d. Date sig	ned (Month	y Day, Year)
	> - 0		▶ 20	Rode	My 140	In		102	00	44		02/	211	08
	1		30. Name and addre	ess of person who	completed cause of de	-) (Type,	Print)		1 1)	A	111	al	
	1./		Elliot	t Hon	baty /	1711		190(31	li	pan 12	- Drive	blen	WIN	ne, Wed 2120
	Sta		31. Date filed (Mont		· · · · · · · · · · · · · · · · · · ·	ar's Signature	6					t		1 7
	Registr	ar	1	EB 25 2	2003	co Ar	1	200						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Smith PM 2008 12:52 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marylana Age (In yrs. last birthday) Yrs. Universit Itimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. Director 10 13 58 MD 212-76-7522 49 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1132 McKean Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes P☐ No Specify. þ Specify: 3 Widowed 4 Divorced Black "natural", 1 and 2 should be filed within 72 hour Health and Mental Hygiene. tem 27 is marked other than "natural other traumatic event, the Medical Ex Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mass Transit Adm. <u>12th grade</u> 4yrs Bus Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Smith Alice B. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra James Dennis-Brother 1122 Hunter Drive, El Paso, TX 79915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 2/26/08 Baltimore Co, Md Funeral Service License 21/Signature March F/H West 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Baltimore, Md Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 40 Carai /Medical Due to (or a va consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 physician a Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) the 9□Unknown 9 Unknown า signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Whiknown Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate 1∏ Yes After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 20 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Lirector: completely filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

DHMH 17 Rev 1/2001

2

Baltimore, Maryland 21215-0036

Box 68760;

P.O.

Division or Vital Records,

FEB25

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Bennis

and manner stated

ne

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Raltimore

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Americal Item 26 per verb., g876,02/25/08dbb en Registrar	alth and Mental H Path	ygiene Reg. No.2008	05670
VS.	Physici	an	1. Decedent's Name (First, Middle, Last) Ronald Smith	2. Date of I Month Feb		3. Time of Death 2:050 M
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc		4c. County of Dea	
1			1000 Franklin Avenue Ess		Baltin	more
6	Funeral Director		217-34-2671 X M 2 F 69 Yrs. Months Days H	Under 24 Hrs. 8. Date of E		thplace (State or Foreign ountry) MD
	and bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary t-f sho fied a	tor	MD Baltimore Essex			1 ∐Yes 2XX No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 1000 Franklin Avenue #818 21221		10g. Citizen of What Co	ountry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ifen 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2X No	nic Origin? (Specify Yes or t Mexican, Puerto Rican, etc.) pecify:	14. Race - Ame Black, Whit Specify: WI	e, etc.
21215-0036	within 72 ho ene. than "natul he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of working	16b. Kind of Business	
	led wi lygien ner th nt, the		12th Printer	. Mother's Name (First, Midd	Baltimon	re sun
Maryland	12 should be filed within n and Mental Hygiene. 'is marked other than' raumatic event, the Me	Be c	17. Father's Name (First, Middle, Last) Henry Edward Smith	Anne Lac		
IZ.	should nd Me mark imatic	မှ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and I			Zip Code)
	1 and 2 Health a tem 27 is		Ronald Smith / son 7200 Conley	Street Balt	imore MD 2	21224
Baltimore,	0 0		20a. Method of Disposition 1	- ;	20c. Location - City or Baltimo	ore MD
Balt	permit. Pag Department Important: I any injury o once.		Connelly	Ave. Baltome of Esse		
68760,	Physician bhysician and physician and physician and physician and street brutan-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Infarci	bár	Interval Between Onget and Death
P.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of de Month	livery Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		t tobacco use contribute to] Yes 2	o the cause of death? robably 4 Denknown
Il Records,		Completed		24a. Wa au pe 1 Yes	topsy prior to death?	utopsy findings available completion of cause of 2 \square No
Vital	Physician: r this certificaral director, I	Be	examiner?	. Place of Death (Check only	-	
o	g Physer this eral di	: To	1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpatient 3 Sec. Injury at 1 Notural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	4 ☐ Nursing Home 5 ☐ 46 28d. Describ	e how injury occurred	спу)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	(Street and Number or R own, State)	ural Route Number,			
_	ne Hospita 24 hours ne Funeral	Medical Certification:	29a. Certifier (Check only one) 1	on, death occurred at the tim	e, date and place, and du-	e to the cause(s)
	To th To th comp	Me	and manner stated. 29b. Signature and till of earliver 29c. License nur D 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F.E. ChaThan Dois North Point B 31. Date filed (Month, Day, Year) S2. Registrar's Signature FEB 2 5 2008	960	29d. Date signed (Monitorial February	th, Day, Year) 7 18, 2008
	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. E. Cha Tham 1005 Non The Point B	3/12/#730	Baltimo	re por zer
	Sta Registr	ite ar	FEB 2 5 2008			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22-2008 Robert Sidney Scherer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) Examiner GLEN HOURNIE ANHE LINE DY SALTIMORE LOACHINGTON MEDICAL PRITE If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Year) Months Days Hours Min 15 M 2 □ F 218-22-8218 02/25/1928 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Director Maryland | Anne Arundel Glen Burnie 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 941 Lombardee Circle 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ TYPES 2 No 1946— If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: þ 3℃Widowed 4 □ Divorced Year or Dates: 1947 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbina marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be : 1 end 2 should be fil Health and Mental H tem 27 is marked otl Farl Scherer Etta Hawk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 end 2
Department of Health a
Important: If Item 27 is
any injury or other trau Robert Scherer, Jr. (Son) 3607 Advocate Hill Drive, Jarrettsville, Md. 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard: 02/26/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEYATO **Physician** disease of condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? es 2 No certificate 2 □ No 1 TYes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the vithin 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MY

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

A COLINS

Glen Burne MD 20161

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Joan Dean Scherer BBBIZUAZY 1285AM 22-2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE AKUNDEL BALTIMORE WASHINGTON MEDICAL CRUTEX CLEN FOURNIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 09/24/1929) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 M 2XX Maryland 216-28-8461 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ◯XNo Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A. 941 Lombardee Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣♣No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumeth. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Social Security 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Franklin Roland Hardbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3607 Advocate Hill Drive, Jarrettsville, Md. 21084 Robert Scherer, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 02/26/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for Month Year Day in the past 12 months? 5 ☐ Other (specify) ed by the a detached f I□Yes 2□No 9☐Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1⊟ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tyes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

30 Name and address of person who completed cause of death (Item 23a) (Type Print)

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🦰 🦰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 910 A **Physician** Stumpt 08 Mary 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hone Nurging Ruvenwood Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 ☐ M 2 🛛 F Months Hours 219-16-7297 90 Director 12**-**12**-**1917 Baltimore Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location od 2 should be filed within 72 hours after death with the Marylar Ith and Mental Hygiene. 27 Is marked other than "natural; or flems 23a or 28a-f show traumatic svent, the Medical Examina must be notilised at 1 X Yes 2 ☐ No MD n/a Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 10 S. Augusta Ave. United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) cashier retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Wilmes Mary Margaret Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 soft Health an item 27 ls Cynthia M. Jissri / granddaughter 3346 Strickland St. Baltimore, MD 21229 20b. Place of Disposition (Name of Cemetery, crematory or other place)
West Arunde1 Crematory2-15-2008 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot) 1 ☐ Burial 27☐Cremation 3 ☐Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licentee Dlar 1328 Sulphur Spring Rd., Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Onot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner In Gection Uriner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as our injury Due to (or as a consequence of): Examiner te attending physician and of for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/MedIcal 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown مـٰ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>≽</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1□ Yes 2⊠No Division of Vital To the Hospital or Attending Physician: within 24 hours atter death.

To the Funeral Director: Atter this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number 2-13-08 1745786 NO

Registrar
DHMH 17 Rev 1/2001

State

Eltew Place, Rultivore

lucen

32. Segistrar's Signature

1714

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

FEB 25

Howard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 23 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 8. Date of Birth (Month, Day, Year) Oct. 11,1928 If Under 1 9. Birthplace (Sta Country) Michigan **Funeral** State or Foreign Days Months Hours 1/□ M 2 🔀 F 79 Director 377-24-9138 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5229 Even Star Place 21044 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Elmer Hyslop ဥ Evelyn Oswald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Shaw 5462 Mystic Court (Son) Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or oti 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Pk. 2-28-2008 Clarksville, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, MD 21045 23a. Part1. Enter the disease or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive Page 10 Veas /Medical vul to (or as a consequence of): Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate perforn Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 ER/Outpatient 3 □ DOA Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Certification: To 1 🗀 Yes 1 ☐ Inpatient this Manner of Dea filled in by the funeral 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal completely 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

FEB 25

2008

31. Date filed (Month, Day, Year)

completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician Year SMITH ROBERT WENDELL 10:45 PM FEB 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner toward County Itos Atal toward Howard ounty If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 68 Months Days Hours Min. 220-36-0332 Yrs. Director MD Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits works r 28a-f sh notified Ellicott 1 ☐ Yes 2 ☐ No toward Funeral Director MD. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n Avenue Wilton 21043 USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other thermany injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 No If Yes, Give Year or Dates: 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gollege (1-4or 5+) Elementary/Secondary (0-12) Worker yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Lrene 100 19a. Informant's Name/Relationship (Type. Print) (French) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 9067 Dun logg in Rd Ellicott City Gardner Kichara Date UNK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility: Cremetron Services 5151 Baltimore Nat'l Baltimore, MA 21229 23a. Part1. Enter the its ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TIC **Physician** 28 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 30 days PNEUMONIA Sequentially list conditions Examiner than y leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed as the burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 (ARDIO MYOPATH) 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 🔀 No 2 **X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours after deau.,

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062560 16,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore, 21231 MICHAEL DRUMMOND 1000 Fell 31. Date filed (Month, Par Fail 5 2008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Sa ORIS 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Home If Under 24 Hrs Hours Min Heritage 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days 1 □ M 2 🖬 216-01-5950 May 18,191 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No **Funeral Director** Nda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 2500 u.S 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sander HERMANN Mary Fischer ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford HNITA Liberty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method-of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemekky 21. Signature of Funeral Se 22. Name and Address of Hicility adley-Ash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUEROTII Physician CARDIO VASCEI /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit THROMBUSS Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wiknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 No within 24 hours after death. To the Funeral Director: A 3☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
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State

FEB 25

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a-c per fb 9876 2-25-08 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZIPM **Physician** + M4 20100 7 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Sex **Funeral** 1-3582 1 M 2 F -34 Months Days 71 Director 1AE4land Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director 1 Yes 2 No Baltimore Md 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2585 USA Avenue 21223 Kamonson Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 17 Yes 2 1 Ne
If Yes, Give Year or Dates 7 5 7 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: à Specify: BLack 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event the Mental Page 18 and Injury or other traumatic event the Menta Elementary/Secondary (0-12) College (1-4or 5+) SANITORAL Maintenance HOOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baltimore, Maryla Kichard arp Logers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15a40. Md 21223 CROPICA MARD Edmonson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Gremation 3 Removal from State md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Pacility Millers Wetropolitain Chapel 21. Signature of Funeral Service Licensee Balto. md. 21213 BROADNOW 1639 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. e, or complications that cause, the death. Do not enter the most of dying, such as cardiac or respiratory arrest, List only on the respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate Division or Vital Records, P.O. Box 6 IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specity) sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown art II. Other significant conditions conlibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Tyes 2 🗌 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **1**₩e 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Itém 28a) (Type, Priet) Registrar's Signature Year) 31. Date filed (Month, Day, State 0 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician; 24 hours after death.

Funeral Director: After this certifica To the Hospital within 24 hours a To the Funeral C

Swart

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Abiodu

29c. License number

8118 Good Luck Rd., Lanham, MD. 20706

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Peter Constantine Sotiriou, M.D. 22. 5:15 P M February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 6. Sex Days Months Hours 1 X M 2 □ F Director 218-44-6295 76 Nov. 6, 1931 Egypt Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ¥Yes 2 No Director п/а Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 Items 23a 5401 Purlington Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No WW II If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married ō 1 ☐ Yes 2 No White þ Specify. 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) r than Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M Physican 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleni Grammata Constantine Sotiriou ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helga Sotiriou (Spouse) 5401 Purlington Way, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Mem. Gardens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signal e of F 1050 York Road, Towson, Maryland 21204 Ottephen Coster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final gastric Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No þ

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ← physician als the burial-t

the

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Be 2 Certification:

within 24 hours after death

To the Funeral Director:

completely filled in by the f

3 CHKHOWH							
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.		se contribute to the cause of death?		
				24a. Was an autopsy performed? 1□ Yes 2 3 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 SOther (Specify) No Specify						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurration and/or investigation	ed at the time, date and place ion, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)		

29c. License number

Charles St

00057926

29d. Date signed (Month, Day, Year)

Baltmore up

24,2008

State

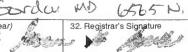
Registrar

the

Medical

31. Date filed (Month, Day, Year) FEB 2 5 2003

29b. Signature and title of certifier,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 03:05FM **Physician** EBRUARY 23, 2008 Serio Frank Anthony /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center 8. Date of Birth (Month, Day, Year) Aug. 31, 1924 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1**X** M 2 □ F Maryland 212-20-7716 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State at 1 ☐ Yes 2 XXIII Examiner must be notified Hunt Valley Director Baltimore Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number within 72 hours after death with ō USA 44 Springhill Farm Court or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 'natural', 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Wholesale Foods than Elementary/Secondary (0-12) College (1-4or 5+) Serio & Sons President/CEO 2 should be filed with and Mental Hygiene. marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gargiulo Amelia James Serio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an tant: If Item 27 Is 44 Springhill Farm Court, Hunt Valley, MD 21030 Rose J. Serio (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/28/08 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages
Department of
Important: If It
any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Dulaney Valley Mem. Gardens 4□pmation 5☑Other (Specitantombment ture of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Sig Stephen Coster 1050 York Road, Towson, Maryland 21204 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner UNRINARY TRACT INFECTION Sequentially list conditions, in arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physiciar as h attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the aid 9 Unknown 9 [] Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performe has s certificate has director, page 2 2 No Yes To the Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? director, Be Other: Hospital 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No ို 1 ☐ Yes 1 X Inpatient this Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours after death

To the Funeral Director:
completely filled in by the f

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

FEB 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

D41410

29c. License number

29d. Date signed (Month, Day, Year) 2018

OSLER DRIVE TOWSON, MARYLAND 21204 7671 M.D. MEHTA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2:22 A M February 22, 2008 Virginia Rachel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 X F Hours Maryland Aug. Director 218-09-1261 88 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21234 LISA 8800 Old Harford Rd # 309 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 VNo þ Specify: White 3 Widowed 4 Divorced Completed er than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M once. Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward F. Schmidt Virginia Thomas ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22205 2229 N. Quantico Street, Arlington, VA Terry Smith (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify)Entombment Dulaney Valley Grdns: 02/26/08 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road, Towson, Maryland 21204 Stephen Coster 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) recu Physician welfs /Medical Due to (or as a consequence of): Examiner weeks Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ traumannd 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No rs after death.
ral Director: After this of Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Fell out of while has while at 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 9:00 AM February, 2008 1 ☐ Yes 2 🗷 No Church services 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mornings de House Shyr Hill 8500 Del Harford Rd Park ut 1 Gertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 8800 Old HARFORD Rd PARKULLE, MHZ1Z3) within 24 hours at To the Funeral D 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e bruity 22, 2008 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G BM 6701 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Smith 15:25 M Harry 22 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/1/1927 Birthplece (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Days Hours 1**X** M 2 □ F 80 Ohio 274-20-8294 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Baltimore Timonium by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 1 Castelbar Court 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1XXYes 2 □ No If Yes, Give Year or Dates: WWII Specify: White 1 ☐ Yes 2XXVo 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Director Volunteer Maryland Non-profit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcus Smith Helen Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Smith / Wife 1 Castelbar Court Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 2/26/2008 Baltimore, Maryland 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Eunera 6 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Uremia Due to (or as a consequence of): Acute Renal Failure Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **X**No 1 Tyes 3 Probably 4 Unknown Myocardial Infarction, Methicillin Resistant Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Staphylococcus kacteremia 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ EB/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed detached pe page 2 should certificate or Attending Physician: this After death. within 24 hours after death To the Funeral Director: filled in by Hospital the

Funeral

Director

or 28a-f ahow

Items 23a

5

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permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I

Physician

/Medical

Examiner

burial-transit

physician

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

the Medical Examiner must be notified at

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Carrie Comptell, Mertical Poctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



RES- UCU

February 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Amend 19a, perInf, G881 7/2/08 Efficience of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2008 22:33 Martha Terry 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bavview Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7-26-1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F 97 Yrs. 215-30-5037 Director N.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1818 N. Washington Street 21213 U S Δ Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1□Yes 2⊠No Baltimore, Maryland 21215-0036 Specify: þ Specify: Black 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Homes 12th grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Williams Minnie Chavis ဥ 19a. Informant's Name/Relationship (Type. Print)

Cornelia Robertson-Terry in-law

Cornelia Terry Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 N. Washington Street Balto, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Tope Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cem 2-21-2008 Baltimore, MD 22. Name and Address of Facility March F/H East 21. Signature of Ineral Service Licensee mallan Brown 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final acon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) ASUT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Winknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) a□No 2 ER/Outpatient 1 🗌 Yes 1 Inpatient 3□ DOA Certification: To this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending investigation s after dea... eral Director; A' 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 38 Wortham Woods Road. 40 21234. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 'Vonande 31. Date filed (Month, Day, Year) State FEB25 Registrar

DHMH 17 Rev 1/2001

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		For State Registrar	State of Mary		Pertificate of		A	eg. No.	di. An	00004
Dharai		1. Decedent's Name (First, Middle, Las)				2. Date of Dea Month	th Day	Year	3. Time of Death
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Examir		4a. Facility Name (If not institution, give		11-11-	10	r Location of Death	1170	4c. Coun	ity of Death	
		THE JOHNS H 5. Social Security Number 6. Se	OPKINS	HOS FIT	-	MORE If Under 24 Hrs.	B Date of Birth		9. Birthole	ece (State or Foreign
Funeral Director		217-66-5590	M 2□F	51 Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day		Counti	MD MD
ene. than "neturel", or Items 23a or 28a-f show he Medical Examinat must be notified at		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	or Location				10	d. Inside City Limits
- Ish	to	MD	N/A	Baltin	nore					1 Yes 2 No
7.28a	Director	10e. Street and Number			10f. Zip Code			0g. Citizen o	of What Count	ry?
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T.	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H		pecify Yes or No- o Rican, etc.)	14. R	ace - America lack, White, e	
d other than "neturel", or Items 23e or 28e-f show event, the Medical Examinational be notified at	b	1 ☐ Never Married	1 □Yes 2 No If Yes, Give X Year or Dates:		1 ☐ Yes 24 No	Specify:		Spec	oify: B]	lack
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natic	L _O	Vermell Thompso 19a. Informant's Name/Relationship (1)		10b A	Mailing Address (Street		a Thomp	, D O 11		
-		Cynthia Thompso			19 Tucker					
other		20a. Method of Disposition		Oh Place of C	ienosition /Name of		Date		n - City or Tov	
ō		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		King I	crematory or other pla. Memorial	Park 2-				own, MD
any injury once.	1	21. Signature of Funeral Service Licen			22. Name and Addre		March E	-		MD 21202
# a		Dlady	o wan						salto,	MD 21202 Approximate
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2 5	Completed						24a. Was		prior to con	psy findings available inpletion of cause of
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2	atic	2 Accident investigation			M 1	Yes 2 No				
d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (- At home, fam Specify)	n, street, factory, office		28f. Location (S City or Tox	Street and Nu yn, State)	mber or Hura	l Route Number,
To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1× Certifying Ph (Check only one) 2 Medicel Exar	ysicien: To the best of r niner: On the basis of ex and manner state	amination and	death occurred at the to or investigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ARA 2008 REAL February /Medical 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. Counity of Death Examiner (0) Del ar Kiverside orien If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 7-22-4063 1 ☐ M 2 🔀 F Yrs. Director MARCK 10, 1922 Usual Residence of Decedent 10b. County 10c. Cify, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director W.D CAMP 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by MOL 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE 6Th. GRAde 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WAITON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Abbina Preston LANC 111 100 DAVId 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Furier I Service Licenses BAIR MD 213/3 ARP1.1257 1129N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MUDGOVOLO disease or condition resulting in death) /Medical Due to (or s a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 (No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an I or Attending Physician: The after death.

Director: After this certificate I 1□ Yes or Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C To the Hospital 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH:17 Rev 1/2001

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2008

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan		-				lental Hy	/giene	•		
			State Registrar	1 4		C	ertifica	e of i	Death)	0 Data of D	Reg. No.	200	8_	05686
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	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent I Armed Forces?		.s. '	3. Was Dece If Yes, spe	dent of H	lispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, W		
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N	or Atter de lirecte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At h c. <i>(Speci</i>	ome, farm <i>fy)</i>	, street, facto	ry, office			28f. Location City or To	(Street ar own, State	nd Number or e)	Rural	Route Number,
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0568 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 **Physician** ANDY 12 NOON H VANSKIVER Feb 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center NA Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 219.75.4313 MD Director 07.14.2006 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Essex MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 1384 Sugarwood Circle Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur VanSkiver Donna Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna VanSkiver/Mother 1384 Sugarwood Cir., Baltimore, MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 02.21.08 Dundalk, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emboli Physician Cerebra disease or condition resulting in death) /Medical Due to (or as a consequence of): 6 days Examiner Cerebro-Vasca Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit Tetralogy On Due to (or as a densequence of): 0+ and attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9☐Unknown 9 I Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral (28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760, Division or Vital Records, e Hospital or Attending Pi 124 hours after death. e Funeral Director: After ti letely filled in by the funera To the Hospital within 24 hours a To the Funeral D completely

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of certifier

Nan garber

31. Date filed (Month, Pay, Year)

- 22 S. greene St, RN NSE13, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

attending PNS 29c. License number

Critical Care Ned D63539

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

18

08-01560

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nrisر	stine Jan W		1- For State Certificate of Death	Reg. No.
	Physic	ian/	Redistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year February 23, 2008 3. Time of Death 1300 hrs
weo	lical Exam	iner	CHRISTINE JAN WELSH 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	
			6402 Beechwood Dr Columbia	Howard
	Funeral Director		719-82-5418 1 M 2 VF H5 Yrs.	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) VA
	w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No
7	yland a-f sho	ctor	MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
163	the Mai a or 28 tified a	Director	6402 BEECHWOOD DRIVE 21046	USA
1 (imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intel: It item 2.75 marked other than "natural", or items 23a or 28a-f show any or other tranmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.) White, etc.
	s after (ral", o	by F	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 V No specify:	Specify: WHITE I of work done 116b. Kind of Business/Industry
	2 hours "natu	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	e retired)
	036 ithin 7 me.	Completed	1 BOOKKEEPER	SMALL BUSINESS
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. injury or other traumatic event, the Medical	ပ္ပိ	The table of table (though the table)	lame (First, Middle, Maiden Sumame) NET MARIE HILL
	212' uld be Mental marke	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rural Route Number, City or Town, State, Zip Code)
	MD d 2 sho lth and n 27 is umati	-		Date 20c. Location - City or Town, State
	es I an of Hea If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	
	ti Page tment rtant:		4 Donation 5 Other Specify: 21, Signature of Funeral Service Licensee 22. Name and Address of Facility	31076 HANOVER 31006-26-61
	Bal permi Depar Impo		2.1.0.3/1.1.0.0.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	ON STRUCKER OF BY HAMON SECT O
7	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	iac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
	/Madica kamine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
			Sequentially list conditions, b	
		iner	if any, leading to immediate Due to (or as a consequence of):	
	ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
	68760, certificate be executed nding physician and ise as the burial - transit	Physician/Medical	X UNPENDED AMENDED 4MENDED 3/10/08 TT	
	3760, ificate be g physicis the buri	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 23c. Fetal death 3 Ectopic pr	23d. Date of delivery regnancy Month Day Year
	Box 687 e death certific the attending p ed for use as th	sicial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
	Aecords, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
	P.C es that iigned !	d by		1 Yes 2 No 3 Probably 4 Unknown
	rds, requir	Completed		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
	Reco	d mo		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
	cian: Certific	Be	25. Was case referred to medical examiner? Hospital: 1 Innation 2 ER/Outnation 3 DOA Other; 1 Doal of the part of	
	F Vi Physic rer this	<u>ا</u>	1 Ves 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Oute'4 N 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	Sursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred
	on c ending sath. or: Af	ļ.	Natural 5 Pending	0
	Division of Vital Records, P.O tal or Attending Physician: The law requires that to safer death. **Al Director: After this certificate has been signed by led in by the funeral director, name 2 should be detected.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phremanal bureance. After this certificate has been signed by the attending phenomial by the funeral director, page 2 should be detached for use as the	Cer	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	a, and due to the cause(s) and manner as stated.
	ithin 2, or the F	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date and place, and due to the cause(s)
	+ <i>≯</i> + ŏ	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 24, 2008
V			30. Name and address of person who completed cause of death (Item 23a)	1 oblidaly 24, 2000
0	A		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201
	, Regi	State		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 17 **Physician** 2008 3:30p Evelyn Westmoreland /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1501 Taylor Avenue N/A Baltimore nder 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2□F 219-10-5110 30 1925 MD Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show idleal Examiner must be notified at 1X Yes 2 □ No Director Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21201 323 Poppleton, Funeral Street 14. Race - American Indian . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Home 8th grade N/AHomemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Jackson Rufus Topp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vivian L. Watts - Daughter | 1501 Taylor Avenue Baltimore, MD 21234

20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) King Memorial Park 2-22-2008 Randallstown, MD 21. Signature of Funer Sorvice Licensee 22. Name and Address of Facility 21202 March East F/H 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastane breas Cance years Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed the burial-transi and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as 1 attending IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy performed? 2 No this certificate 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) House examiner? 2 No Hospital: 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient 2 House To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann Pr Death 28b. Time of 28d. Describe how injury Certification: 1 latural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

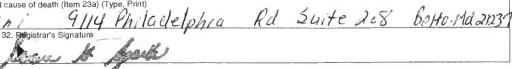
State Registrar

31. Date filed (Month, Day, Year) FEB25 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certification

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc. 20b per 1h g8/6 2-25-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Year **Physician** B:00AM 03 02 6 /Medical Good In the control of the control o 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Godd Samaritan Hospital Baltimore
Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Virginia 1 □ M 2 □ F 225-34-9422 80 Director Nov. 15, 1927 Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show notified at 10b. County 10c. City. Town or Location 10a. State 1□Yes 2□No Director Maryland N/A Baltimore 10f. Zip Code 21229 10g. Citizen of What Country? 10e. Street and Number #2M ŬSA "natural", or ttems 23a or 3600 W. Franklin Street Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 □Widowed 4 □ Divorced Completed th and Mental Hygiene.
7 is marked other than "natui traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chestnut Ridge Elementary/Secondary (0-12) College (1-4or 5+) Country Club <u>8th grade</u> Chef 18. Mother's Name (First, Middle, Maiden Surname)
Mary Smith 17. Father's Name (First, Middle, Last) Be Mary Unk. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Department of Health al Important: If Item 27 is any Injury or other trau Shirley M. Harris/Daughter 9328 Fitzharding Lane Owings Mills, Maryland 20b. Place of Disposition (Name of Arthur 118) rematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) bustus Memorial Arbutus, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 3a. Part1_Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Metastortu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Winknown 1 🗌 Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes □□No 24a. Was an autopsy certificate 1∐ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 27. Man of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Vear) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signarule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 3. Time of Death nt's Name (First, Middle, Last) 2. Date of Death **Physician** 02 200 7 /Medical 4c. County of Death If not institution, give Location of Death Examiner 8. Date of Birth (Month, Day, If Under 1 Year (In yrs last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 ▼ F Yrs. 0 -Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If then 27 is marked other than "nature!" ---" any Injury or other transmitted. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1**X**Yes 2 ☐ No Director Himore 10g. Citizen of What Country? 21216 Funeral 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) iar 18. Mother's Name (First, Miles Be ပ State, Zip Code) 20a. Method of Disposition 1 Burial 2 □Cremation 4 □Donation 5 □ Other (ocomoke Ctu 3 Removal from State 5 Other (Specify) Service Licensee 21. Signature of Funeral ile, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the dilath. Do not enter shock, or heart failure. List only the cause of a chiline. Immediate Cause (Final disease or condition MOUNE **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transi signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month detached for in the past 12 months? Year 5 Other (specify) 1 Tyes 2 🗆 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate 2 2 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 TYes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier

State Registrar

25

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician -chruan 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Itimore Washington Medica 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖼 216-28-8065 76 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A +lanta 21122 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician OSMC Important: If item 27 is marked other any Injury or other traumatic event, the Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ၀ KRAMER au LINE 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) land HHLANTA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o 22-08 4 ☐ Donation 5 ☐ Other (Specify) Bradley - ASNON FUNERAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muscodie /Medical Due to (or consequence of): Examiner pokemi A Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be execute attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♠ No 3 □Ectopic pregnancy be detached for Month Year 1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed 2 **10**10 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 2 **X**0 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA မ 1 TYes 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier C W of person who completed cause of death (Item 23a) (Type, Print) pakusod Road Glen Burnie MD 2106 <u>7</u>845 Muhases

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

R15

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 11:31 AM 2008 leher FEB 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST- ACINES HEALTHCARE BALTIMORG Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** 1 M 2 4 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore ARBUTUS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1232 Stevens WSH 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) [NStaller permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) dwara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE Weber - 40 ther , Md 21222 DUNdalk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Cemekey Baltimore, MD 2-21-08 4 □ Donation 5 □ Other (Specify) Bradley - Ashton Funeral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, SDrING Rd. 21222 2134 WILLOW Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MRSA PHEUMONIA 2 YA GF /Medical Due to (or as a consequence of): Examiner acalculous CHOLE CYSTITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transi attending physician and Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Hepatitis Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 No certificate 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital

within 24 hours after death.

To the Funeral Director: After this I or Attending Fafter death. Hospital

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

P19923 Suvae chala MD

FEB , 17,2008

,21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 S.CATON AVE, BALTIMORE SUVARCHALA COMPELLA

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Restrar's Signature

1/2

DHMH 17 Rev 1/2001

Physician /Medical Examiner The law requires that the death certificate be executed as the burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the burial detached signed by

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Exemination

page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After th
completely filled in by the funeral

			-		
shock, or heart failure. List only	plications that caused the death. Do not ente	r the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Phemonia				
resulting in death)	Due to (or as a consequence of):			4	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			1	1
Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):				
	_ d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
Part II. Other significant conditions	contributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to	the cause of death?
			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical		26. Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Spec	cify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inj		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		et, factory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,
	nysician: To the best of my knowledge, death miner: On the basis of examination and/or inv and manner stated.				
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	h, Day, Year)
> SOUL	Doctor	Resool	Fei	ormary 19	,2008

, 3001 South Hanover Street Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sairan Bashir

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 14, 2008 Physician 4:00 A.M Robert Ashley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If nct institution, give street and number) Examiner 3527 Wilkens Avenue Baltimore 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1935 Tennessee 1 3 M 2 □ F 72 408-56-4187 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c, City, Town or Location 1 Yes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 3527 Wilkens Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 💢 No Specify: 2 3 ☐ Widowed 4 ▼ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Machine Operator 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Pearl Manis Ballard R. Ashley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3527 Wilkens Avenue; Baltimore, MD 21229 se of Disposition (Name of Date 20c. Location - City or Town, State Denny C. Ashley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State iew Cemetery 2/18/2008 Marriottsville, MD 22. Name and Address of Facility Sterling Asiton Schwab Witzke Mount View Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 1901490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death retoro Vascular acci dent Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi to (or as a consequence of) attending physician Physician/Medical use as the IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No page 1∐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl une Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 1 Inpatient 2 ER/Outpatient 3 DOA ္ဝ 1 🔲 Yes this funeral c 27. Manner Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Jural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

be executed Box 68760, P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

State Registrar

Medical

and manner stated. 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 02/15/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

08-01583 Natanael Alavez-Va	aso	Please Type o	or Print in Bl of Maryland	ack ind	l <mark>elib</mark> l tmen	e Ink. Er	nsure h and	All Co Mental	pies Are Leg I Hygiene	jible.		
Trataria o Trataria	1- P	For State				of Death				g. No	20	3, Time of Death
Physician/ Medical Examine		. Decedent's Name (First, Middle,Latential NATANAFT). ALAVEZ—							Month February 2		Year	0921 hrs
g		a. Facility Name (if not institution, gi	ve street and number)				ocation of D		4c. Cou	inty of Death	1
Ţ	Ļ	Baltimore Washington Me		e (In yrs. las	t hirthda	Glen I	r 1 Year		24Hrs. 8. Date of Bin		Arundel	thplace (State or
Funeral Director	5	. Social Security Number 6. S	MEX 2 F		st Diftinge	Months		+	Min. NOV. 2		Foreig	
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w any		0a. State 10b. County		10c. City, T		Location						10d. Inside City Limits 1 X Yes 2 No
1958 or 28a-f show fried at once	<u>ا</u>	MD 0e, Street and Number		ARBU	JTUS	10f. Zip	Code		1	0g. Citizen o	of What Cou	intry?
th the Maryland 23a or 28a-f sh notified at once		910 HOOPER AVE				212	229			MEZ	(ICO	
		1. Marital Status	12. Was Deceden		5. 1	3. Was Decede	nt of His	panic Origin , Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	14.	Race - Ame White, etc.	rican Indian, Black,
r death with or trems 23 raust be no		1 Never Married 2 X Marrie		X No		1 X Yes 2			MEXICAN	Spe	cify: WH	ITE
2 hours after "natural", Examiner	⋧┞	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	mpleted)	16a. De	cedent's Usual	Occupat	ion (Give kir	nd of work done		of Business	
72 hou mail mail mail forter		Elementary/Secondary (0-12)	College (1-4 or	5+)	dui	ring most of wor	king lite	DO NOTUS	se reurea)			TO I CITIOD
5-0036 iled within 77 Hygiene. I other than the Medical	najaidiiioo	9TH 17. Father's Name (First, Middle, Las	.+1		P	AINTER		18.Mother's	Name (First, Middle,			TRACTOR
215-0 be filed and Hyg rked of		ALFJANDO ALAVEZ						BERNA	ARDA VASOU	EZ CA	STELLA	ANOS
ID 21215-003 should be filed within and Mental Hygiene. 77 is marked other the natic event, the Med		19a. Informant's Name/Relationship	(Type, Print)		100				er or Rural Route Nu			. 11
rre, MD 2shows 1 and 2 show of Health and 1 If item 27 is 1 rer traumatic	-	XICO ALAVEZ/BRO	THER	20b. F	3° lace of 1	15 N. B Disposition (Nat	EAUM ne of ce	ONT AN	VE., BALTI	20c. Loca	ation - City o	21228 or Town, State
Ore, ges 1 a t of He		1 X Burial 2 Cremation 3		State C	remator	y or other place)	}	3/01/2008		TINCHA	
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27	-	4 Donation 5 Other Special Other Other Special Other Other Other Special Other O	fy:	ICEM	ENTE	RIO MUN 22. Name and	Addres	s of Facility	WESLEY CH	AVIS,	JR. F	NRL. HM.
Ba Pern Imp Imp	1	MINIELA CAM	win 4.			2007-	-09	EASTER	N AVE., B	ALTIMO	DRE, M	
Physician Madical		23a. Part I. Enter the disease, or cor failure. List only one cause on	each line.			enter the mode	ot dying	, such as car	rollac or respiratory at	rest, snock,	Of fleat	Between Onset and Death
raminer	1	Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arr									
		Sequentially list conditions,	b Due to (or as a con	and and a	n.							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	е.									
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68760, certificate be noting physics so se the burner.	Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo				3	Ectonic	pregnancy		Date of deliv	ery Day Year
688 certific	cial	past 12 months?	4 Pregnant	at time of de	ath 5	Fetal death Other (Spe		Lotopio	programoy			,
BO) ne death	Physician/Medic	1 Yes 2 No 9 Unkno	9 OHKHOWII	oth but not r	oculting	in the underlyin	n cause	given in Par	rt I. 23e. Did	tobacco use	e contribute	to the cause of death?
P.O. sthat sthat deta	b F	Part II. Other significant condition	is contributing to de	ath but not n	esulting	in the anachym	ig cadao	givon	1 TY	es 2 N	No 3 P	robably 4 🗸 Unknown
rds, require been signould b	Completed					-			24a. Wa	s an opsy	prior 1	autopsy findings available o completion of cause of
ecoi he law ite has l	duc								per 1 🗸 Yes	formed?	death 1	
al R	ပ္ထ	25. Was case referred to medical examiner?						oe of Death (Check only one)			
F Vit. Physici	P P	1 ✓ Yes 2 No	Hospital: 1 Inpa	ntient 2		tpatient 3 ime of Injury	DOA 28c. Ini	ury at Work	Nursing Home 5 28d. Describ	Residence how injury		her:
nding I th.	ö	27. Manner of Death 1 X Natural 5 Pending	(Month, Da	y,Year)	200. 1			Yes 2	l			
r Atter ter dea irrector	ficat	2 Accident Investig 3 Suicide 6 Could r	28e Place of	f Injury - At h	ome, far	m, street, facto	ry, office	building, etc	c. 28f. Location or Town		Number or	Rural Route Number, City
Div pital o	Certification:	4 Homicide determ	ned (Specify)									
he Hos in 24 h he Fur pletely	Medical	29a. Certifier 1 Certifying Physical Cone 2 Medical Exami	sician: To the best of ner:On the basis of e	f my knowled xamination a	lge, dea and/or in	th occurred at the vestigation, in r	ne time, ny opinio	date and pla on, death oc	ice, and due to the ca curred at the time, da	iuse(s) and te and place	manner as s e, and due to	o the cause(s)
To t	Med	29b. Signature and title of certifier	and manner state	ed				nse number				Month, Day, Year)
		Jack !	Ter in	m			0.0	C.M.E.		Febru	uary 25, 2	2008
		30. Name and address of person w		of death (Iter		111 Popp	Street	Baltimo	re, MD 21201			
1 FM	a to	Tasha Greenberg MD. 31. Date filed (Month, Day, Year)	32. Regis	trar's Signal				., Dalimo	,			
Registi		FEB 2 6 20	08 Alberta	4000	19	as the s						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

eted cause of death (Item 23a)

Assistant Medical Examiner egistrar's Signature

2008 6

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Pepn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 23, 2008

29a. Certifier 1

30 Name and add

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

FEB

one)

Medical

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician A^{M} Agnes February J. Adams 20, 2008 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🖸 F Director 147-70-0543 83 February 29,1924 Guyana Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√ No Director Maryland Montgomery 01nev 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Ex-miner must be r 3308 Llewellyn Field Road 20832 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Head Mistress Private School other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, t 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Wilfred Adams Mabe1 Andris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claire N. Agard / Daughter 3308 Llewellyn Field Road, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, MD. Gate of Heaven Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 21. Signature of Funefal Service Licensee M01193 fritu h 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dancisendo /Medical Du- o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1- State Registrar Amend 19a, perMD, g876 2/28/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear BROWN 2005 10-25 AM WILLIAM FEB /Medical 4a. Facility Name (If not institution, give street and number)
(YVLT) MED, (AL CENTER) 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON YORK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 18 1918 BALT, MORE 7700 ROAD Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 1**∑**M 2□F 217-07-3052 Director Ohio Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No N/ABaltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4100 N. Charles Street, Unit 1115 21218 White Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after of Hygiene "Hygiene" other than "natural", or iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Executive <u>Printing</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill and Mental H William Edward Brown, Sr. Beulah Miller Jre, M.
Jermit. Pages 1 and 2 sho.
Department of Health and Important: if I tem 2 any Injury or any 193 Informant's Name/Relationship (Type, Print)
Wife
B. Brown - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 4100 N. Charles Street, Unit 1115, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 2/25/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H., Williams 22. Name and Address of Eacility Cremation Society of Maryland, Inc. HULL 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUNONIA Priysician disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner years STAGE DENTENTIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsecuance or certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 NO 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) funeral B Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spepte MD D0053150 5002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMB, A UPTA 9650 Santiago RD ShakunMALA 2045 31. Date filed (Month, Day, Year) FEB 2 6 gistrar's Signature 32. State 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 19,2008 **Physician** Bradsher M. Bowen 8:05 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5759 Edgepark Road Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 04,1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. Days Hours Months 1⊠M 2□F Roxboro N.C. 239-46-4098 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 28a-f show a or 28a-f show be notified at TYPYes 2 No Baltimore N/A Maryland Director 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 United States 5759 Edgepark Road items 23a the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Korean 1台Yes 2回No Korean If Yes, Give Conflict Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trailmetic. Elementary/Secondary (0-12) College (1-4or 5+) Office Personnel Bethelhem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Bowen Florence Brown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) (wife) Mrs. Mary Jo (nee Arthur) Bowen 5759 Edgepark Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel Feb. 25, 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 Approximate Interval Between Onset and Death Part . Enter the discuse, or complication shock, or heart failure. List only one cau Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-trar Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 ☐ Unknown signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes ■No 24a. Was an autopsy performed' certificate ! Hospital or Attending Physician; 25. Was case referred to m_dical examiner? funeral director, 26. Place of Death (Check only one. Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

32. Registre's Signature

4 EAST Rolling Crussoads Baltinore, Md.

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

and 2 should be filed within 72 hours after

Pages '

altimore, Maryland 21215-0036

Certification: To

Medical

Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

> 29c. License number D0053928

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEGUM, MD - 2434 W. BELVEDERE AVENUE, BALTIMORE, MD -. MD - 21215

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certif



DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral L

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician Month Z008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give stree and number) 4b. City, Town, or Location of Death Examiner Ba Panda Kandallstown Date of Birth (Month, Day,) ial Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months 92 1915 Director 212-18-3649 July Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sudbrook Lane 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black þ If Yes, Give ** Year or Dates: Specify 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Randallstown 9109 Liberty Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5 NOther (Specify) in state Signature of Euneral S. W. ROHALI State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner stage rena Egypermany flat conomons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Box 68760 signed by the attending physician d be detached for use as the buria death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. P 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Tyes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? this certificate 2 □ No 2 🗆 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation spital or Attendii ours after death. neral Director: A 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a hours 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Signature and 29d. Date signed (Month, Dav. Year) and a

Registrar

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filed (Month, Day, Year,

Registrar's Signature

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Edgar Lee Britenstine commy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **1X**XM 2□ F 333-24-2880 90 02/15/1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2\no Severn Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8220 Quarterfield Road U.S.A. 21144 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. TXXYes 2 □ No If Yes, Give 1 Never Married XXMarried 1 ☐ Yes XXNo Specify Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sergeant U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Britenstine Carrie Woods 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Mrs. Martha E. Britenstine 8220 Quarterfield Road, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/25/2008 Chesapeake Cremation: Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD NC01357 Singleton Funeral & Cremation Services 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death?

The law requires that the death certificate be executed led by the attending physician and detached for use as the bunal-transi Division or Vital Records, P.O. Box 68760, page within 24 hours a To the Hospital completely

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Certification: To Be

Medical

29b. Signature and title of certifier

ML 31. Date filed (Month, Day,

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

or other traumatic

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Physiclan /Medical **Examiner**

altimore, Maryland 21215-0036

demont A				Y Sorres 2□	No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 Yes 2 Who	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ O	Hospital: hpatient 2	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	i □Other (Specify)
27. Manner of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	/ occurred
3 Suicide 6 Could not be 4 Homicide determined		nome, farm, street, factify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one) Certifying Ph 2 Medical Example (Check only one)	nysician: To the best of my knowner: On the basis of examin	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)

State Registrar

29c. License number

29d. Date signed (Month, Dav. Year)

Name an ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		1	For State Registrar	State of Maryla	-	artment of H <i>rtificate of l</i>			iene eg. No.	05705
	day.	_	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Year	3. Time of Death
	Physicia /Medic	_	TERESA		BROC	COLO		02	2) 200	
	Examin		4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County of Dea	
			JOHNS HOPKING H			1.43	MORE CI			1/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(Year)	rthplace (State or Foreign Country)
	Director		215-28-7352	W ZAL	74 Yrs.			AUG. 2	2,1933 MA	ARYLAND
	w	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Aaryla sho ed at	5			RATE	TIMORE				1 X Yes 2 □ No
	the N	Director	MD N/A		LAU.	10f. Zip Code		1	0g. Citizen of What C	Country?
	with tage			REET		2	1231		U.S.A	<i>A</i> •
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral		12. Was Decedent Ever i	in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - Am	nerican Indian,
_	r iter	F	Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No				o Hican, etc.)	Black, Wh	
2-0036	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	102-11	1 ☐ Yes 2X No	Specify:		Specify: WI	HITE
5	72 ho natur ical I	sted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Busines	s/Industry
Z	within 72 ene. than "na' he Medic	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	I				CT OUITE	I.C
Z	filed wi Hygien other th	Completed	7		F.A(CTORY WO		no (First Middle	CLOTHII Maiden Surname)	NG
yiand	tal H d oth	Be	17. Father's Name (First, Middle, Last)	10 T O			PHILC		BONADIO	
<u>Xa</u>	ould Men narke	P _L	ALBINO BROCC		10h Mail	ing Address /Street			er, City or Town, State	Zin Code)
Ma	2 sh n and ls m		19a. Informant's Name/Relationship (Ty							MD. 21224
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene are strong item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items to notified at other traumatic event, the Medical Examiner must be notified at	1	JOANNE RADFORD/ 20a. Method of Disposition		b. Place of Disp	osition (Name of	į.	Date	20c. Location - City	
Baitimore,	to file or o		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cit	ematory or other place	(e)	2/25/08	BALTIM	ORE MD
	rt. Partmer rtant riant		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens							
g n	permit. Pages 1 au Department of Hea Important: If item any Injury or othe		21. Signature of Fuller Follows	1		LILLY &	ZEILER	INC. FU	UNERAL HO	MD. 21231
-			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the	death. Do not er	1901 EAS	ng, such as cardia	c or respiratory ar	rest,	Approximate
			shock, or heart failure. List only o							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor		ARTERY	THROM	1305/5		3 weeks
	Examiner			Due to (or as a cor	isequence oi).					
×	*	e.	Sequentially list conditions,	b Due to (or as a cor	nsequence of):					
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0						
a a	exec in and ial-tra	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
8760,	cate be executed physician and s the burial-transit	dical		d						
•		0	IS SEMALE.	-						
. Box	death certiff e attending d for use as	N/ug	23b. Was decedent pregnant	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐		□Ectopic pregnanc	у		23d. Date of Month	delivery Day Y <i>e</i> ar
	deal	sicie	in the past 12 months? 1 ☐ Yes 2 No	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)	<u> </u>		ino.	24,
0	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	Physician/M	9 Unknown		A	d-dvia	ron in Best I	23e Did to	obacco use contribute	to the cause of death?
Ś	es th igned be de	by	Part II. Other significant conditions co	ntributing to death but no	nt resulting in the	underlying cause gr	en in Fait i.	1 🗆 1		Probably 4 Unknown
Records, P	equir sen s	Completed								
ပ္ပ	E SI S	ple						24a. Was autop	an 24b. Were prior prior death	autopsy findings available to completion of cause of
<u> </u>		Son				_		1□ Yes	2 No 1 □Y	es 2□ No
Vita	Attending Physician: Throeath. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?	Hoppitalt			or:	ath (Check only o		
7	hysi this c	은	I Yes ZRINO	7-1	2 ☐ ER/Outpati	ettr 3 DOA			dence 6 Other (S	pecify)
Ē	ing P	ö	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye.		/ Wo	rk?]Yes 2 □ No	200. Describe i	now injury occurred	
<u>S</u>	tend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury	At home farm s		7103 2 110	28f. Location (5	Street and Number or	Rural Route Number,
Division or	or A after of Direction by	Certification:	4 ☐ Homicide determined	building, etc. (S	Specify)	,		City or To	wn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier TV Certifying Phy	ysician: To the best of m	y knowledge, de	ath occurred at the t	ime, date and plac	e, and due to the	cause(s) and manner	r as stated.
	24 hr 24 hr 9 Fun etely	Medical	(Check only 2 Medical Examone)	niner: On the basis of exa	amination and/or	investigation, in my	opinion, death occ	curred at the time,	date and place, and	due to the cause(s)
	To the I within 2.	Me	29b. Signature and title of certifier	7.4		29c. Licen	se number		29d. Date signed (M	
	FSFO		DATA Dens	homas N	1D	RE	5 000		February	21,2008
1	V		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print)	1 0			
0	1		Katherine Thoma	15, 600	North W	29c. Licen RE e, Print) /cife Stre	et Baltir	nore, M	ID 212	87
7	[,] St	ate	31. Date filed (Month, Day, Year)	32. giştrar's	Signature	0	1			
	Regist	rar	LERY P S	008	. # 4	Sugal 1				

Registrar
DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of M	aryland /		artment <i>tificate</i>			and M		giene Reg. No.2	118	05706
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ıth	<i>y</i>	3. Time of Death
	Physici /Medio		Vernon Leroy	Cooper						-	Month Februar	y 22	2008	5:23 a M
	Examin		4a. Facility Name (If not institution, give	street and number,			4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	
			Manor Care Roland					ltimo					N/A	
	Funeral		5. Social Security Number 6. Se	x 7. Ag ¶M 2□F	ge (In yrs. last I 86	birthday) Yrs.	If Under Months	1 Year Days	Hours Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	(, Year)	Coui	
	Director		218-05-6340 Usual Residence of Decedent		00						JUL 5	1921	Mary	Land
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	e-f sl	ctor	MD Baltimon	ce	Tows	on								1 □ Yes 2 No
	or 28	Oire	10e. Street and Number	" 117			10f. Zip					-	of What Cour	ntry?
	ath w	rai	7925 York Road, Ro					L204				USA		
	hours after death with the Maryland turei, or items 23s or 28e-1 show all Frechment be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 X Yes 2 □	?	13. \	Nas Deced f Yes, spec	lent of Hi ify Cubar	spanic Ori n, Mexican	gin? (Spe ı, Puerto l	cify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
38	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2 No	Specify:			Spe	city: Wh:	ite
5	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		Sa. Deced	dent's Usua	I Occupa	ition	t of worki	0.0	16b. Kind o	f Business/In	dustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us		uring mos	I OF WORK	''g			
7	ygler ygler her th	S	9		'1	ruck	Driv	ver	40.14.4		(77)		nsporta	ation
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. marked other than "naturel", or items 23s or 28e-1 show imatic event, it e Medical Eracuter must be notified at	Be	17. Father's Name (First, Middle, Last) Norman Ralph	Cooper					Anna		(First, Middle, ertha	Gilln		
<u>=</u>	s 1 and 2 should of Health and Men item 27 is marke other traumatic.	안	19a. Informant's Name/Relationship (T)		10	9h Mailir	a Address	(Street a			I Route Numbe			Code)
<u>≅</u>	and 2 sho ealth and n 27 is m		Robert Eads - Cour				-				imore,	-	1212	, 6656)
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place						ate		on - City or To	own, State
Ë	Pages nent of int: If it		1 ☐ Burial 2 Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State						2/23	/2008	Balti	imore,	MD
altimore,	permit. Pages Department of importent: If it any injury or c		21. Signature of Funeral Service Licens	^e H Willi							of Mary			
ñ			1 Sinti	VIIII	- Carris	2	299 F1	cedei	rick	Road	, Balti	more,	MD 2	1228
г			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that cause ne cause on each I	d the death. Di	o not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
d	Priysician		Immediate Cause (Final disease or condition	Ummu	Oh	sohn.	din	1	who	m	Drze	~	. 1	Onset and Death
н	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):		_	. 0	,				
	LAGITITICI	<u></u>	Sequentially list conditions,	- Cry	a consequenc	1	earl	7	rili	re			-	
T	ted nsit	nine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	M	a consequenc	12. L	188	تا ب						
V	execun n and iai-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):	100							
8760	ficate be executed physician and s the burial-transit	dicail		d										
0	tifical ng phy as th	Medi												
ROX	eath certific attending p	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal dea	ıth 3□	Ectopic pr	egnancy					Date of deliv	
	e dea	sici	in the past 12 months? 1 Yes 2 No 9 Unknown		t time of death		Other (sp						Month	Day Year
л О	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Phy	Part II. Other significant conditions co		out not reculting	a in the u	adoshina o	auca anvo	o in Dart I		23a Did to	phacco use c	contribute to t	he cause of death?
Hecords,	signe d be d	d by	Tatti. Ottor significant contamons co	itibuling to death	out not resulting	g in the di	idenying o	2030 GIVE	REHET CLILE			′es 2□No		
Ö	w require been sign	etec									24a. Was	20 24	Ib Were auto	psy findings available
Ř	The lav	Completed									autop	sy med?	prior to co death?	mpletion of cause of
			25. Was case referred to medical						26 Place	of Death	1 Tes	2 No	1 🗌 Yes	2L No
>	ysician: is certific director,	o Be	eyaminer?	fospital:	ent 2□ER/0	Outpatien	t 3 🗆 DO	A Othe			me 5 ☐ Resid		Other (Specia	(v)
O	ding Phy Ther thi	n: T	27. Manner of Death	28a. Date of Inj	ury 28b	Time of		8c. Injury Work			28d. Describe h			,,
Ö	andin ath. or: Af	atio	1 Accident 5 Pending investigation	(month)	,, , , , , , , , , , , , , , , , , , , ,	,0, y	М		res 2□	No				
Division	r Atto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, tc. (Specify)	farm, str	eet, factory	, office		1	28f. Location (S City or Tow		ımber or Run	al Route Number,
	urs af													
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manners	of examination	ge, death and/or inv	occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the d ed at the time, d	ause(s) and date and plac	manner as s ce, and due t	tated. o the cause(s)
	o the	Med	29b. Signature and title of certifier	and maintel s			29c	License	number			29d. Date sig	gned (Month,	Day, Year)
	- s - ō) Das.	N		m1)		D 3	146	1		21	22(0	5
	H		30. Name and address of person who co	ompleted cause of	death (Item 23a	a) (Type,	Print)					- 1		
	Φ,		SHUA113 A. 1495	Hon1 8	2(N.	EU	TAN	ST	In	te 3	508 13	176711	MOISE	MU 2726
	Sta		31. Date filed (Month, Day, Year) FEB 2 6 20	08 32. (egist	rar's Signature	A	rack)	,						
	Registr	ar	1 20 0 20		A 20	87	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D25, February 2008 Gerard Donald Carroll Sr. 5:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3102 Hillcrest Avenue Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 17,1929 79 Months Days Hours **₩** M 2 D F 212-26-4355 February Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Marvland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Hillcrest Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 EYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Sprinkler Fitter/Fire Protection Union Local 536 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Carroll Mary McMann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don Carroll Jr. 400 Blueberry Court, Edgewood, Maryland 21040 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood 20a. Method of Disposition March 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkville, MD. 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) buniths ancer Due to (or as donsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed 1 Yes 2 No 1 ☐ Yes 2☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

certificate be executed

Box 68760,

P.O.

Division or Vital Records,

Physician:

or Attending

the Hospital

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

/Medical

10a. State

Director

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Completed

Be

Examiner Physician/Medical the asn Por detached \$ Completed

attending physician the ģ certificate has this filled in by the funeral After death. within 24 hours after death To the Funeral Director:

Be

2

Certification:

Medical

29a. Certifler

3701

(Check only one)

29b. Signature and title of ertifier

Registrar

25. Was case referred to medical examiner? a No 1 Tes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

My

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

21224

28f. Location (Street and Number or Rural Route Number, City or Town, State) 😥 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29c. License number D0033897

MD

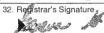
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date-signed (Month, Day, Year) 08

State

31. Date filed (Month, Day, Year) FEB 2 6 2008

aste-n



and manner stated.

AUr

Baltomera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret Russell Crehan 22**,**2008 February 5:40 A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Apt.E. Baltimore County 2 Swampscott Court Carney 8. Date of Birth (Month Day, Year) NOV • 24 , 1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1□M 2ĂF 89 Hours Baltimore, MD. 212-16-2875 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Baltimore County Carney Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21234 2 Swampscott Court Apt.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore County Govt. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matilda J. Billingsley John C. Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carney, Maryland 21234 2 Swampscott Court Apt.E. Mr. Weldon Ira Crehan (Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel Februar 25, 2008 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service License e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each lim. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

, o.

'natural",

the Medical

Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, the once.

Director

Funeral

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Completed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician ar as attending properties for use as by the a has reen sign te he director After this funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 2 210 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles Street

29d. Date signed (Month, Day, Year)

Suite 615 Towson, Maryland

21204

James Ricely, D.O.

32. Registrar's Signature 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		partment of H ertificate of I		lental Hy	giene ,	2008	0570	-
		в	Decedent's Name (First, Middle, La	st)				2. Date of De	eath		3. Time of Death	_
	Physicia		Margaret	Harley Clary				Month Februar	Day	2008	1:01 A M	
35 19 3 3	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	restaut		unty of Death		_
			300 Northway Ct.			Reis	terstown			Balt:	imore	
	Funeral		5. Social Security Number 6. S			Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birthp Coun	ace (State or Foreign	_
, la	Director		210-14-3720	□M 2\$\overline{X} F 8.5) Yrs			Feb. 2	8, 192	22 Mar	yland	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location				1	0d. Inside City Limits	_
	Maryli f sho ed at	or		imore	D = 4						1 ∐Yes 2t∏No	
	the 28a-	Director	10e. Street and Number	Imore	кет	10f. Zip Code			10a. Citizer	n of What Coun	try?	-
	3a or		300 Northway C	f		,	.136		USA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 1	3. Was Decedent of H If Yes, specify Cuba		ecify Yes or No		Race - Americ		_
9	be filed within 72 hours after death with the Maryland tall Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give		**	Specify:	Hican, etc.)		Black, White, opecify: Wh	ite	
215-0036	hours ural", il Exa	d by	3 Nidowed 4 Divorced	Year or Dates:	10. 5					oony.		
5	"nat	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	1 (G	ecedent's Usual Occup live kind of work done of e. DO NOT use retired	during most of work	ring	16b. Kind	of Business/Inc	lustry	
	withi ene. than the M	ЩC	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		lomemaker	,			Own He	nme	
D	i filed I Hygir other ent, tl	Be C	17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle	, Maiden Su		31110	-
Maryland 21		TO B	William Harley Sn	vder			Marga	aret Ni	cholso	on Payno	2	
ar	2 short and N is ma	_	19a. Informant's Name/Relationship (ailing Address (Street	and Number or Rur	ral Route Numb	er, City or To	own, State, Zip		
	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Bryan W. Clary/so	n	1314	Windemere	Ave., B	alto.,	MD 212	218		
ore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Place of Di- cemetery, of	sposition (Name of crematory or other plac	ce)	Date	20c. Locat	tion - City or To	wn, State	
Ē	: Pages tment of I tant: If Its		4 ☐ Donation 5 ☐ Other (Specif	y) A1	l Sai	nts Cemete		5/08	Reis	stersto	wn, MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice			22. Name and Address Lemmon Fun	eral Home	e_of Du	1aney	Valley	Inc.	
Н			23a. Part 1. Enter the disease, or som shock, or heart failure. List only	Tagle plications that caused the dea	ath. Do not	10 W. Padc enter the mode of dyir	nla Koad g, such as cardiac	or respiratory a	um Ma errest,	ryland	Approximate	
	Physician		Immediate Cause (Final	one cause on each line.	on	Y F.	6,0311				Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):						Yrs	-
	Examiner		Sequentially list conditions	b. =								
7	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):							
V	and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	nuence of):							_
09/80	ficate be executed physician and is the burial-transit				4							
		edical		u								
ROX	eath certif attending for use as	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1□Live birth 2□Fe		3 □Ectopic pregnancy			23d	I. Date of delive	ery	
a	The law requires that the death cert to has been signed by the attending age 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		5 Other (specify)				Month	Day Year	
J.	at the de I by the a stached	Phy	9 🗆 Unknown									_
ŝ	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but not re	sulting in th	e underlying cause giv	en in Part I.			contribute to tr	ably 4 Munknown	
Ö	requi	eted										_
Vital Records,	has the law	Completed						24a. Was		24b. Were auto prior to coi death?	psy findings available npletion of cause of	
			25. Was case referred to medical					1□ Yes	2 1 No	1 □ Yes	2□ No	
5	sicia certi irecto	Be c	examiner?	Hospital: 1 ☐ Inpatient 2[TER/Outpa	tiont 30 DOA Oth	26. Place of Deat er:			7011		-
Ö	g Physer this eral dii	7: To	27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. Injur	4 Nursing Ho	28d. Describe			//	-
0	Attending Physician: r death. ector: After this certifics by the funeral director, i	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Inju		K? Yes 2 □ No					
_	L, Φ L _	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec		street, factory, office		28f. Location ((Street and Nown, State)	Number or Rura	l Route Number,	
2	oital o urs aft eral Di	Cer										_
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my ken niner: On the basis of examinand manner stated.	nowledge, denation and/o	eath occurred at the tir r investigation, in my c	ne, date and place, prinion, death occur	and due to the rred at the time	cause(s) an , date and pl	nd manner as si ace, and due to	tated. the cause(s)	
	To the To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)	_
	^		I Roll &	Me		103	5 2000 5		2/	21/2	228	
	10		30. Name and address of person who	completed cause of death (Ite	em 23a) (Typ	pe, Print)	Carto.	0	· R	Perstan	form, Ml	
Ť,	Sta Registr		31. Date filed (Month, Day, Year)	32. Figistrar's Sign	naturo	horse						
1	negistr	41	FEB 2 6	2008 Asserve	90							

08-01442 Janice Cook

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05710

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As Excellent environment of control of the property of the control of the cont		/ 1	Decedent's Name (First, Middle,Last)		Date of Death Month D	ay Year	3. Time of Death
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To compare the compare of the compar		4			1		
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The control of the co			217-21-2849 _{1 M} XX _F 19 Y		6 - 21	-1988 Co	untry) Maryland
Marry Land N/A Baltimore 10		t	Usual Residence of Decedent				10d Jesido City Limite
The content of the		1	Tour otatio				
A company of the part of the	land f show	<u>.</u>	17.1		100	Citizen of What Cou	
Security of the control of the contr	Mary Canada				109		
Security of the control of the contr	23a of 100 co		11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Amer	
Security of the control of the con	eath w	lae.	1 X Never Married 2 Married Armed Forces?	f Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.	
Second of the control of the contr			3 Widowed 4 Divorced If Yes, Give Year or Dates:				
Second Part	hours a		during	dent's Usual Occupation (Give kind of most of working life. DO NOT use re		16b. Kind of Business/	industry
The state of the s	54 °	blet		N/A		N/A	
The state of the s	d with	5					
Ricky E. Keffer Brother 2629 Miles Avenue Baltimore, Maryland 21211 2020. Mentod of Disposition 2020. Execute Operation Name of Descention Name of Committee of Control of the Control of the Control of Con	215 be file mtal H. rked o	8	A THE RESIDENCE OF THE PROPERTY OF THE PROPERT				7.0.11
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Physician Microbia (Control of Payment) (Control of	MIC seath a salth a cm 27 raum:		20a Method of Disposition 20b. Place of Disp	position (Name of cemetery,	Date	20c. Location - City o	r Town, State
Physician Microbia (Control of Payment) (Control of	Ore ges 1 g t of H t of H		1 KXBurial 2 Cremation 3 Removal from State Crematory or Oakla	other place) wn Cemetery (2/2	25/2008	Baltimore	, Maryland
23. Part I. Enterfusé disoass, ol-Vomplications that caused the death. Do not enter the mode of dying, such as cerdad or respiratory area, shock whether failure. List only one couse on each line failure. List only one couse on each line failure. List only one couse on each line. 23. Part I. Enterfusé disoass, ol-Vomplications that caused the death. Do not enter the mode of dying, such as cerdad or respiratory area, shock whether failure immediate cause. Enter full-little and the control of the c	Itim it. Pa urtmen ortant	_	4 Donation 5 Other Specify:	O Name and Address of English			
Table 1. Six only not cause of the latest the control of the course of t	Ba Depr Imp		May Huputu MO0841 B	Burgee-Henss-Seit: 631 Falls Road J	z Funeral	Home, Inc	21211
Translate Cause (Final deases of condition resulting in death) Sequentially list conditions, condition resulting in death) Sequentially list conditions, in death Due to (or as a consequence of): Due to (or			23a. Part I. Enterthe disease, or complications that caused the death. Do not enter	er the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	
Due to (or as a consequence of): Constitution with processing in death) Due to (or as a consequence of):			Immediate Cause (Final disease a. Oxycodone intoxication				Death
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The state of the s			if any leading to immediate Due to (or as a consequence of):				
The state of the s		ᆵ	(Disease or injury that initiated				
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past 12 months? Yes 2 No 9 Unknown g Unknown	760, cate b		IF FEMALE: 23c. If yes, outcome of pregnancy		inancy		
296. Signature and title of certifiel Control Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Figister's Signature 33. Figister's Signature	certification	cia)	past 12 months?				1
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O.C.M.E. February 20, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31, Date filed (Month, Day, Year) 32. Faister's Signature	To the within To the comp	Med	and manner stated.				
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31, Date filed (Month, Day, Year) 32. Figister's Signature			1 -	O.C.M.E.		February 20, 2	800
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			30. Name and address of person who completed cause of death (Item 23a)				
	<i>b</i> 1		Carol Allan, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21	201		
Registrar FRZ b 2000 Application				hard			

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Registrar

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30. Name and address of person who completed cau

Fay

31. Date filed (Month, Day,

3730

se of death (Item 23a) (Type, Print)

Falls Road

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 8877 3-20-08 yt.
State of Maryland Poepartment of Health and Mental Hygiene

		,	For State Registrar	State of Mar	-	epartmen Certificat			1ental Hy	giene Reg. No.	201	08 05712
	Dhusial	2	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	eath Day	Y	3. Time of Death
g.	Physicia Medic		Violet Eleanor Ca	arlson					Febru			оов 4:58 Р м
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)				ocation of Death		4c.	County of	
	LUI	Ą	6007 Bedford Ln. 5 Social Security Number 6.8	2 400	(In yrs. last birtl		intor	If Under 24 Hrs.	0 Data of Bi	rth		ce George's Birthplace (State or Foreign
S	Funeral Director			XX 89		rrs. Months	Days	Hours Min.	8. Date of Bi (Month, Di May 26	ay, Year) 191		Country) Minnesota
	magner willight dates		Usual Residence of Decedent				1		ridy 20	,		
	irylan show 1 at		10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 21 No
	ne Ma 18a-f 1	Directo	Maryland Prince G	eorge's	Cli	nton				40. 000		45
	a or 2		10e. Street and Number 6007 Bedford L	ane		10f. Zip	0735					at Country? tates
	be filed within 72 hours after death with the Maryland Hylgiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.			panic Origin? (Sp , Mexican, Puerto	ecify Yes or N		4. Race -	American Indian,
ထ	after o		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give				i, Mexican, Puerto Specify:	Rican, etc.)			White, etc.
Maryland 21215-0036	ural",	Completed by	3XXWidowed 4 □ Divorced	Year or Dates:		1 ☐ Yes	1111			14 15 15 15	Special h	
2	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usua (Give kind of wo	al Occupa rk done du se retired)	tion uring most of work	ring	16b. Kir	nd of Busin	ness/Industry
12	withir lene. than he M	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)) _	leperso				Sal	l.e	
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<u>lar</u>	should be filed wand Mental Hygie s marked other t umatic event, th	To B	Antti Sat	omaa				Fann	ie Sato	maa S	Sikki	la
lar)	2 sho and I is ma	ľ	19a. Informant's Name/Relationship			-		nd Number or Rui		-		
	and lealth m 27 her tr		Jean Richter	(Daughte	·			Lane, C1			20735	ty or Town, State
altimore,	Pages 1 and 2 should be nent of Health and Ments int: If item 27 is marked iny or other traumatic e		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐]Removal from State	1			Feb 27	, 2008			
<u>=</u>	permit. Page Department of Important: If any injury or once.	V,	4 Donation 6 Other (Special Structure) of February 121. Senature of February 121.	y)	Fort I	Lincoln	Cemet	tery	_			d, MD
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	- 4		23a. Pari1. Enter the disease, or com shock, or leart fail and. List only	iplications that caused the	he death. Do n						1, 110	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a								
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89	ng ph	Medi	IF FEMALE:									1 month
õ	death certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pt 1 ☐ Live birth 2	Fetal death					2	3d. Date	of delivery h Day Year
P.O. Box	he de the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	5 ☐ Other (sp	pecify)					,
٦.	res that the de signed by the a be detached f		Part II. Other significant conditions	contributing to death but	not resulting in	the underlying c	ause give	n in Part I.	23e. Did	tobacco u	se contrib	ute to the cause of death?
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000	aw require s been sig 2 should t	Completed	Dementia						24a. Wa			ere autopsy findings available
m m	sician; The law certificate has b irector, page 2 s	om	Dysphagia, A	nemia						opsy formed? 2\(\sum_\) No	de	or to completion of cause of ath?]Yes 2 No
Vital	clan; ertifica ctor,	Be C	25. Was case referred to medical examiner?				255	26. Place of Dea		one)		
2	Physic this c	2	1 □ Yes 2√□ No	Hospital: 1 Inpatient		tpatient 3 DC	DA Othe	7: 4 ☐ Nursing H	ome 5 Res	sidence (Other	(Specify)
Division or	ding F	ion:	27. Manner of Death 1. Whatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day		njury M	28c. Injury Work 1 □ Y	at ? ′es 2 □ No	28d. Describe	now injur	y occurred	
lsi.	after death Director: In by the	ficat	3 Suicide 6 Could not b	e 28e. Place of injur	y - At home, far				28f. Location	(Street an	d Number	or Rural Route Number,
	al or safter	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or I	own, State)	
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier XX Certifying P. (Check only one)	hysician: To the best of miner: On the basis of e and manner state	examination and	, death occurred d/or investigation	at the tim	e, date and place inion, death occu	, and due to th rred at the time	e cause(s) e, date and	and mani place, an	ner as stated. nd due to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier	a mainor state		290	c. License	number		29d. Dat	e signed ((Month, Day, Year)
)			MADULU OL				D1-	1843		2	25	08
	71		30. Name and address of person who			Type, Print)						
			Valik Vaid, M.D 31. Date filed (Month, Day, Year)	. 3311 Tole		race B10	2, H	yattsvil	le, MD	2078	32	
	Sta Registr		FEB 2 6 2008	SE TIEGISTIAL	1/ Son	BI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** QS AM M SUSAN CORNET 2008 Feh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug • 31 • 1951 7. Age (In yrs, last birthday 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 220-60-4616 1 □ M 2504 56 Yrs DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 □ Yes ŽŽNo MD Howard Elkridge Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6621 Deep Run Parkway 21075 USA Funeral ral", or items ? 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: white 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: 2 3 Nidowed 4 Divorced Year or Dates or than "natura the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event, the Medione. Elementary/Secondary (0-12) College (1-4or 5+) Account Manager Phone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Eldridge Barrack Frances Jane Mitchell ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7120 Eden Brook Drive, Columbia, MD 21046 Chessie Cornett/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
West Arundel Crem. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Odenton, MD 2/25/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Ave., Laurel, MD 20707 KenSkil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner myocardial torction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Atheroscleratic Cardiovaccular physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as attending | 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No nenthenia 24a. Was an has autopsy performed? Hylbertension certificate 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2/4NO 1 Inpatient P 1 ☐ Yes 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation Injury 1 Awaturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FEB26

WILLIAM BOYCE, Howard Co Hospital 32. Registrar's Signature 2008

Merce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0043662

Feb 21, 2008

21044

5755 Cedar Lane Columbia, MD

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryland	-				Mental Hy	giene			
Registrar					ot)	Certificate of Death					Reg. No. 2 5				
	1. Decedent's Name (First, Middle, Last) Physician /Medical 1. Decedent's Name (First, Middle, Last) G.				·	Cawthorne Jr.				Month Februar		, 2008	12:30A M		
1	Examin				e street and number)			4b. City, To	wn, or Loc	ation of Deatl	h	4c. County of Death			
		A	858 Cork Elm Court				Severn						Anne Arundel		
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1217-44-8946 121 M 2 F			ge (In yrs. last birthday) 63 Yrs.		If Under 1 \ Months D	Days Hours Min. (M.		(Month, Da	e of Birth onth, Day, Year)		9. Birthplace (State or Foreign Country) VA	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10							10d. Inside City Limits					
		Director	MD Anne Arundel Severn								1 ☐ Yes 2 🛣 No				
		Dire	10e. Street and Num	nber		10f. Zip Code						10g. Citiz	zen of What Cou	ntry?	
		rall	858 Cork	Elm Cou			21144						S.A.		
920		by Funeral	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:			Was Deceden If Yes, specify 1 ☐ Yes 2🏋		nic Origin? (S lexican, Puerl pecify:	pecify Yes or No to Rican, etc.)		14. Race - Amer Black, White Specify: W		
21215-0036		leted	(Speci	1	16a. Decedent's Usual Occupation (Give kind of work done during most of wo				rking	16b. Kir	nd of Business/I	ndustry			
212		To Be Completed	Elementary/Secondary (0-12) College (1-4or 5			Management								rnment	
			17. Father's Name (First, Middle, Last)				· ·					t, Middle, Maiden Surname)			
Va Va			Harold G. Cawthorne Sr. Juanita Wilmer												
Maryland			19a. Informant's Na								ural Route Numb	-		p Code)	
			Mrs. Dawr 20a. Method of Disp		ne/Wife	20b. PI		SOTK EL sition (Name natory or othe		- ;	vern, MD		44 cation - City or 1	own. State	
Baltimore,			1X Burial 2	☐Cremation 3 ☐	Removal from State	- 1				Feb	. 29, 008		•	,	
a E			21. Signature of Taral ervice Licensee 22. Name and Address of Facility Singleton Funeral & Crematic												
Ä			Mo/41/ Services 1 2nd Avenue SW Glen Burnie, MD 21061												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property that the funeral director is a specific to the funeral director.		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
			Immediate Cause (Final disease or condition resulting in death)										Oncot and Boam		
		ner	Due to (or as a consequence of):												
			Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or I	nditions, mediate	as a consequence of):										
		Examiner	that initiated events												
50,		Be Completed by Physician/Medical	resulting in death) L	ast	a consequence of):										
68760,					_d		·-				·	<u> </u>			
P.O. Box 6			IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live birth	outcome pf pregnancy ve birth 2 □ Fetal death 3 □ Ectopic pregnancy regnant at time of death 5 □ Other (specify) hknown						23d. Date of delivery Month Day			
			3 , 3 ,									cco use contribute to the cause of death?			
ord			1 ☐ Yes							Yes 2	2 No 3 Probably 4 Unknown				
or Vital Records,												an psy ormed? 2 1 No	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 ☐ No	
Vita			examiner?	Was case referred to medical examiner? Legalitation 26. Place of Death (Check only examiner)							ath (Check only o	one)			
5		٦.	1 Yes 2 No No No Notice 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5									Residence 6 Other (Specify)			
on		tion	27. Manper of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 28d. Describe how injury 48d. Describe how in									/ occurred			
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)									ral Route Number,			
		Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
_			29b. Signature and	title of certifier	On .			29c. L	icense nu	mber		29d. Date	e signed (Month	-	
					110	MD			0501				2 25	2008	
1	T		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Downing												
V			31. Date filed (Mont		Load Sur	ar's Signal	oo (-	len Bu	INN	c MD	21061				
	Sta Registr		Date med (retent	FEB26	32. Registr	JAR.	A I	GOONE!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Vear Physician Month 00 2008 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimor Iniversity N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 27 1935 Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 M 2 □ F 217-34-1049 72 IL Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No "natural", or items 23a or 28a-f sh e it al Examiner must be notified Director Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25813 Hunters Point Lane 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer US Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is marked other any injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corsini Theresa Gullo ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25813 Hunters Point Lane, Denton, MD 21629 Katalin Hegedus 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 25 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc 2008 Baltimore, Maryland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Şervice Licensee Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part I Enter the disease, r complications that caused the shock, or heart failure. List only ne cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final psis **Physician** resulting in death) /Medical Due to (or as a onsequence of): Examiner 50 W. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine certificate be executed and burial-tran Due to (or as a consequence of) physiclan Physician/Medical the as attending use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy o Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probabiy 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2₩ No 2 ER/Outpatient 3 DOA ဥ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Box 68760, Division or Vital Records, P.O.

State Registrar (Check only one)

29b. Signature and title of eertifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Year)

Greene

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State o	of Marylan		artment of rtificate of	Health and Death		377. 77%	08	05	716			
Physici	an	Decedent's Name (First, Middle			2. Date of De Month Februar	Day	/ear	3. Time of De							
/Medic	al 🤻	Harriet L 4a. Facility Name (If not institution	ee Coo	4b. City. Town.	or Location of Deat	ry 22 2008 07:00 PM									
Examin	er		orien Nursing & Rehab					Columbia				Howard			
Funeral Director		5. Social Security Number 219-30-4636	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 7	ast birthday) Yrs.	If Under 1 Year Months Days			th ay, Year) 15 1934	9. Birthplace Country)	e (State or F	Foreign			
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vith the	Director	10e. Street and Number				10f. Zip Code	04044		10g. Citizen of Wh		<i>†</i>				
feath v	Funeral	6334 Cedar Lar	12. Was Dec	edent Ever in U	.S. 13. \	Was Decedent of	21044 Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	o- 14. Race	USA - American I					
Maryland 21215-0036 td 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	if Yes. Gi	2 No ve No		f Yes, specify Cu 1 ☐ Yes 2 ☐ No		White, etc.							
5-0 72 ho "natur dical	eted	15. Deceden (Specify only highe	dent's Usual Occu	a during most of wo	orking	16b. Kind of Busi	b. Kind of Business/Industry								
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Dre, Marylai es 1 and 2 should b of Health and Ment filem 27 is marked r other traumatic e		19a. Informant's Name/Relations	, , , ,	- m)	ŀ	•			ner, City or Town, S	, ,	de)				
Hea ther		Douglas Coon 20a. Method of Disposition			Place of Dispo	sition (Name of matory or other pl		Date	, MD 2112 20c. Location - C		State				
altimore, mit. Pages 1 ar partment of Hea portant: If Item 3 y injury or other		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				Nationa		h 04 008	Washingt	ton, D)C				
Baltimor permit. Pages Department of Important: If its any injury or o										Funeral Home, P.A.					
4 60286	,	23a. Part I Boler the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between October 1981.													
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALWE Due to (or as a consequence of): CHRONIC OBSTRUCTIVE RUMONARY DISEASE b. CHRONIC OBSTRUCTIVE RUMONARY DISEASE									en ath				
/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):		2	A A Largue	tie-u						
- Zaminici	er	Sequentially list conditions, if any leading to immediate b. CHRONIC OBSTRUCTIVE NUMBERS Due to (or as a consequence of):													
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	edical	d.													
Geath certification of for use as	y Physician/Me	iF FEMALE: 23b. Was decedent pregnant	Ectopic pregnan	CV			23d. Date of delivery								
. 0 0 0		1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown							Month Day Year						
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n Or ng Phy fter this neral di		27. Manny of Death 1 Natural 5 □ Pendir	28a. Date		28b. Time of				how injury occurre						
DIVISION I or Attending after death. Director: After in by the fune	catic	2 Accident investigation M 1 Yes 2 No													
DIVI after d Direct	Certification:	Suicide 4 Homicide 4 Homicide 4 See. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							8f. Location (Street and Number or Rural Route Number, City or Town, State)						
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier (Speck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
thin 24	Medical	and manner stated. 29c. License number 29d. Date signed (Month, Day,													
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		31. Date filed (Month, Day, Year)	WHE TERM	eqistrar's Signa	20 B	ACKKI	LEU UR	acks.	# 109 K	AUI	NURE	, MC			
Sta	te	FCD 9	6 2008	Sa. a	K	sach !									

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month)

EB

ORIGINAL

32. Redistrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **Physician** 2008 6:20 AM Eugenia Diakidis /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. PA 1 ☐ M 2 🕱 F 217-22-8945 79 May 21, Director 1928 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

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Department of Health and Mental Hygh
Important: If flem 27 is marked
any injury or other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Chumbos Maria Kotsakas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Vardavas/Friend 1316 Old Fallston Rd., Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Demetrios Cemetery₀₂₋₂₇₋₂₀₀₈ Cub Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signaturg of uneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical SS nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown AORTIC STENOSIS page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe res 2 certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Natural i Director: Af d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after dea To the Funeral Directo completely filled in by th 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-24-08 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOO M D ... 32. Registrar's Signature 7601 TOWSON. MARYLAND 21204 OSLER DRIVE. TAT-TEE FRANCIS 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Ma	aryland		artment of F <i>rtificate of</i> .		Mental Hy	giene Reg. No.			
H			1. Decedent's Name (First, Middle, La	st)	<u>.</u>				2. Date of De		200		3. Time of Death
	Physici /Medic				orsey				Feb.	07,			7:15 P M
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Death	1	4c.	County of D	eath	
	Funeral	11.	1830 Montreal Ro 5. Social Security Number 6. S		e (In yrs. las	t birthday)	If Under 1 Year	evern If Under 24 Hrs.	8. Date of Bi	rth	Anne A		de1 ce (State or Foreign
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	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Fown or Lo	ootion						
	faryla shov	ō			Toc. City,	IOWII OF LO	cation					100	 Inside City Limits 1 ☐ Yes 2 ☑ No
	the N 28a-f notifii	Director	MD Anne A	rundel			10f. Zip Code	Severn		10a. Citi	izen of What	Country	
	3a or		1830 Montreal Ro	a d				1144			nited		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.		L 1 4 4 lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		14. Race - Al Black, W	merican	Indian,
20	after		1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	lo		1 □ Yes 2 X No	Specify:	o modri, etc.)		Specify:	mie, eu	u.
2-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a Daced	lent's Usual Occup	ation		16h Ki		31ac	
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Z	2 should be and Mental is marked or raumatic ev	ပ္	Frederick Pri	•					Matthe				
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<u> </u>			1 ☐ Burial 2 【X] Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specit</i>			-	natory or other plac	· i	12 2000			М-	1
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			23a. art1. Inter the disease, or com shock, or heart fallure. List only	one cause on each fin	ie.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,		A It	Approximate nterval Between
	Physician	501 2	Immediate Cause (Final disease or condition resulting in death)	a. de	rep	ven	ons th	romb	asso				Onset and Death
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ָּה ה	The law requires that the death ate has been signed by the atten bage 2 should be detached for u	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ng in the ui	nderlying cause giv	en in Part I.	23e. Did				cause of death?
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VII	rslcial s certii lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2□EF	2/Outnation	t 3□ DOA Oth	er:	ome Res		C 🗆 Oahaa (0		
5	g Phy ier this	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	y 2	8b. Time of			28d. Describe			респу)	
VISION OF	endin ath. or; Aff	atio	Natural 5 Pending investigation	1	real)	Injury		Yes 2 □ No					
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc		e, farm, str	eet, factory, office		28f. Location (City or To			Rural F	Route Number,
2	pital ours ai		29a. Certifying Ph	ysician: To the best of	of my knowle	dae deet	a coourred at the tir	mo date and place	and due to the				and .
	To the HospItal or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		niner: On the basis of and manner sta	examinatio	n and/or in	vestigation, in my o	ppinion, death occu	rred at the time	, date and	d place, and	due to the	he cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0			29c. Licens	e number		29d. Dat	te signed (Mo	onth, Da	ay, Year)
	7		·	wam,	M	W)	11448	24		2/20	0/68	
1	0 '		29b. Signature and title of certifier 30. Name and address of person who KOMM M 31. Date filed (Month, Day, Year)	completed cause of de	eath (Item 2:	3a) (Type,	Print) Ritchi	e Hry s	rite 13	40	Pasaa	len	MPUM
ľ	Sta Registr	te ar	31. Date filed (Month, Day, Year) FEB 2 6	32. Registra	ar's Signatur	е	Carte						
			1 Man 45 6		W	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State amend #5&1 1. Decedent's Name (First, Middle, I				modio			2. Date of Dea			3. Time of	Death
Physic	ian	Howard	C.	E.	delman	n			Month Februa		2008	18:41	
/Medi Exami		4a. Facility Name (If not institution, g			acimari		own, or l	Location of Dea		_	nty of Death		
Exami	ilei	Holy Cross Hospi		•		•		Springs		Mont	gomery	7	
Funeral Director				Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		If Under 24 Hrs Hours Min		, 1918	9. Birth Balti	place (State o intry) More, MI	or Foreign
D >		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	eation					T	10d. Inside Ci	ity Limite
aryla ehov	ò		moru.	1	ockvil								2 X No
the N	ect	Maryland Montgo 10e. Street and Number	mer y	10	0011111	10f. Zip 0	Code			10g. Citizen	of What Cou	intry?	
death with the Maryland me 23a or 28a-f ehow must be notilited at	Funeral Director	14411 Traville G	arden Ciro	cle Ap	t B111	1	208	50		U.	S.A	•	
death	era	11. Marital Status	12. Was Decede	nt Ever in U.			nt of His	panic Origin? (Specify Yes or No no Rican, etc.)	14. F	Race - Ameri		
or Ite		1 Never Married 2 Married	Armed Force	X No	1	rves,spec⊪ l∐:Yes 2¶		Specify:	no Alcan, etc.)	l l	Black, White,		
ral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s:			•						
natu	Completed	15. Decedent's (Specify only highest of			(Give	lent's Usual kind of work DO NOT use	done du	tion uring most of wo	orking	16b. Kind o	f Business/Ir	ndustry	
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Hygi Hygi ent,	a)	12 years 17. Father's Name (First, Middle, La.	st)		PICCI	unic		18. Mother's Na	chlesing				
Mental Wental	To B	Howard C. Edelma	ınn					Lucie S	chiesing	er			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Iteme 23a or 28a-f show any njury or other treumatic event, the Macical Examiner must be notified at once.	-	19a. Informant's Name/Relationship	(Type, Print)			-			lural Route Numbe				
aalth an 27 I		Howard Edelmann	Son				The same of the same of		Heathsv				
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta		lace of Dispo emetery, cren				ruary	20c. Locatio			
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Permit.	ì	21. Signature of Funeral Service Lic	ensee)	00					Home Of				
70 E 4 0		Millong	CONC						it Road,		k,Md.	21222 Approximate	to
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	eumon								days	
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ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_c Co	ngest	tive I	Heart	Fa	ilure				hou	rs
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physic the bi	dical		d. dem	nentia	ž							year	S
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death certifica e attending ph ed for use as th	iciar	in the past 12 months?		t at time of de		Ectopic pred Other (spec					Month	Day	Year
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fune fune	ij	1X Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of la (Month, I	Day Year)	Injury	м	c. injury Work' 1 Y	? es 2 □No		,,			
r dea ctor	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of			eet, factory,	office		28f. Location (S		mber or Rui	al Route Num	nber,
s afte	Certification:	4 Homicide determine	building,	etc. (Specify	"				City or Tov	vii, state)			
The state of state of the state	edical (29a. Certifier (Check only one) 1 Certifying I	Physician: To the be aminer: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred at restigation, i	t the time n my opi	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as : ce, and due !	stated. to the cause(s	s)
vithin Ko th omple	Me	29b. Signature and tyle of certifier	4			29c.	License	number		29d. Date sig	ned (Month	, Day, Year)	
100		> cm/	NO			D00	6188	7]	Februa:	ry 19,	2008	
り		30. Name and address of person wh	o completed cause o	of death (Item	23a) (Type,	Print)							
		Dr. Ira Rabin	10810 Cow	n Aven	ue. Ke	nsind	ton.	Marvla	nd 2089	5			
	1	31. Date filed (Month, Day, Year) FEB 2				7		- 1012 / 10	=000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 24, 2008 7:30 рм Ange1 FauntLeRov D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1500 Long Quarter Court Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Aug. 02, 1 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 I 189-18-9641 84 Pennsylvania Director 1923 Aug. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified Md. Baltimore Timonium 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be r 1500 Long Quarter Court 21093 USA ural", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö Completed by 1 ☐ Yes 2 🕱 No Specify Specify: 3 X Widowed 4 ☐ Divorced White natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be

Physician /Medical Examiner

marked

Department of Health and M Important: If item 27 Is marl any injury or other traumati once.

Makarewicz

Mr. Brian Ciany/ Son in Law

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Walter

20a. Method of Disposition

death certificate be executed

ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Physician/Medical þ Completed director, Be ٩ funeral Certification: After To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A filled in by the

P.O. Box 68760,

Division or Vital Records,

21. Signature of Funeral dervice License 22. Name and Address & Fashin Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS 9c Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 **N**0 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of eath

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28h Time of 28d Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem.

Josephine Meregrzynowicz

20c. Location - City or Town, State

Timonium, Md.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Long Quarter Court Timonium, Md. 21093

Date

2-27-08

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed ca

0114

Medical

of death (Item 23a) (Type, Print)

and manner stated.

BURLES

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	-			∕lental Hy	giene		
			State Registrar	Cer	rtificate of L	Death		Reg. No.	008	05/22
	Physicia		1. Decedent's Name (First, Middle, Last) ELIZABETH	F	LEISHEL	-L	2. Date of De Month	Day	Year 2008	3. Time of Death /2:/4A M
	/Medic Examin	4.6	4a. Facility Name (If not institution, give street and number)			Location of Death			unty of Death	
			HARBOR HOSPITAL		BALTIM				N/A	
÷.,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV . 1	th sy, Year) 6 193	Cou	place (State or Foreign ntry) MD
	p.		Usual Residence of Decedent	, Town or Lo	onting					10d. Inside City Limits
	aryla show	<u>-</u>		, TOWITOI LO						1 ☐ Yes 2 [X] No
	he M 28a-f otifile	ecto	Maryland Anne Arundel		10f. Zip Code	adena		10a Citizen	of What Cou	
	a or	Funeral Director	263 Mallard Drive		Tor. Zip Code	21122		rog. Oluzon	USA	
	eath	era	11 Marital Status 12. Was Decedent Ever in U.	S. 13.1	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	₎₋ 14.	Race - Ameri	
30	be filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	o Rićan, etc.)		Black, White, pecify: W	nite
2-003p	thou atura cal E		15. Decedent's Education	16a. Decer	dent's Usual Occup	ation		16b. Kind	of Business/Ir	ndustry
<u> </u>	in 72 in "in in "in Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	kind of work done of DO NOT use retired	during most of wor d)	king			
7	d with giene ar tha the I	ĕ	Elementary/Secondary (0-12) College (1-4or 5+)		Cook			Gro	cery St	tore
p		Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle	, Maiden Su	rname)	
/lan	should be and Mental s marked o umatic eve	은	James Dryer			Doroth	<u> </u>	ills		
	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street					ip Code)
≥,	₽ 5 5 ₽		Joseph Fleishell (husband)	263		Drive, F				
saltimore	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		I Bunai 2 Kicremation 3 Hemoval from State		osition (Name of matory or other plac	1, 4,2,2			tion - City or T	
<u>E</u>	. Pag tment tant: Jury		4□Donation 5□Other (Specify) Met		ematory I					Maryland
Ra	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee		2. Name and Addre 3111 Mo	untain R	oad, Pas	sadena	eral H , MD 2	ome, P.A. 1122
18	MUSE .		23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	o not ent	ter the mode of dyir	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between
ı	Physician	Ш	Immediate Cause (Final disease or condition		STNAL					Onset and Death 2 WEEKS
	/Medical Examiner	ш	resulting in death) Due to (or as a consequence of the control of			_	250			
	LAGIIIIICI	Ļ	Sequentially list conditions, if any leading to immediate Due to (or as a consequence)	uonoo of):						
T	pe tis	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jerice oi):						
/	xecut and al-trar	xan	that initiated events c	uence of):						
20	ate be executed hysician and the burial-transit	dical E								
χς.		edic	0.							
ROX	leath certific attending p I for use as	M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta	incy				230	d. Date of deli	very
	e deatl	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of d		□Ectopic pregnance □ Other (specify) _	у			Month	Day Year
J Ö	at the de i by the a stached	hy	9 ∐ Unknown	72			oos Did	*-t		the course of death ?
Vital Records,	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resi	inting in the u	underlying cause giv	en in Part I.		Yes 2□		the cause of death? bably 4 Unknown
ပ္က	aw re	Completed					24a. Was	an a	24b. Were au	topsy findings available completion of cause of
ř	The late ha	m _O					auto perf 1∏ Yes	ormed?	death? 1 ☐ Yes	./
<u> </u>	sician; The law certificate has l irector, page 2 s	Be C	25. Was case referred to medical examiner?			26. Place of Dea				
	Physic rthis ce ral direc	To		ER/Outpatier	nt 3□ DOA Oth	ner: 4 Nursing H	lome 5 ☐ Res	idence 6 [∃Other <i>(Spec</i>	cify)
Division or	ding Pl h. After ti funeral	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time o Injury	Wo	ryat rk? ∣Yes 2∐No	28d. Describe	how injury o	ccurred	
NISI N	I or Attendi after death. Director: A	ifical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At h building, etc. (Specif	ome, farm, st			28f. Location	(Street and I	Number or Ru	ıral Route Number,
	tal or A safter al Direction by	Cert	4	y/ 			City of TE	wii, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one) 1 Medical Examiner: On the basis of examination and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens				signed (Month	
	•	1 8	PHYSIC	IAN	RE	5001		Febru	ary 2	3,2008
•	m		30. Name and address of person who completed cause of death (Iter							
					. HANCUE	ER STRI	EET B	ALTIN	10RE	MD 21225
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signal FEB 2 6 2008	K A	and the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:17 AM Ann S. Gooding 22 /Medical 02 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death sastul 11360 Hospice 1Le 4+ 1 COMI CO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Days Hours Director 212-36-4959 69 Oct. 1938 Usual Residence of Decedent 2 should be filed within 72 mounts and Mental Hygiene.
I smarked other than "natural", or Items 23a or 28a-f show I smarked other than "natural", or Items 29a or 28a-f show marke event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28119 Crosscreek Dr. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Clerk</u> Automotive permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar R. Sparks Jennie Baublitz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Gooding, Jr./husband 28119 Crosscreek Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/27/08 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Lineral bervice Lio. nsee Michael Flagle 10 W. Padonia Rd., Timonium, MĎ 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TASTA COLON ME CARCINOUN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 1100 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ 40 ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Box 68760, Records, or Vital To the Hospital or Attending Division within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

GHUMM WARK

OASTAL HOSPICA

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

P.O BOX 173) SHUS BUNYUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Robert Burton Gray 18,2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince Cheverl Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day Yea Sept 21, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1 → M 2 □ F Months Days Hours Min. 402 40 7518 75 1932 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐Yes 2☐No MD P.G. Fort Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9016 Larkwood Ave 20744 UNited States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. 11. Marital Status 1 ∏Yes 2 □ No. If Yes, Give Korean Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes 2/17 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Logistics Worker Dept of Defence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Haywood Gray Mable Bolen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iva Gray (Wife) 9016 Larkwood Ave, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Feb 19, 2008 Clinton, MD 22. Name and Address of Facilitae Fuenral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee MU1391 Alexandira Ferry Road, CLinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 unsto T wound Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 5%

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760, certificate

as been signed by the 2 should be detached page After this funeral dir Director: /

Funeral

Director

"natural", or items 23a or 28a-f show

the Medical

other traumatic

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than '

permit, Pages Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Physician/Medical þ Completed Be မ 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: lnjury Nav rear) | Injury | 28c. Injury | 28c. Injury | 1 | 28c. Injury | 28c. Injury | 1 | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 1 | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c. Injury | 28c 1 □ Natural 5 ☐ Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 90/6 LAKE work determined 4 Homicide of 24 hours the Funeral Directory of the funeral Directory rome Fort wash 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

State Registrar

SALVATOR 31. Date filed (Month, Day, Year, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene
26 per verb 2876.02/26/08dbb

			1 - State Registrar Amend Item	26 per ve	ryland / 1 c b., g8 70	epa Cer	2/26/08di	lealth a Death	and Me	ntal Hyg	giene Reg. No. 2	008	05725
10.0	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ronald Graf						2	Date of Dea Month	Day 0	Year Oo	3. Time of Death
	Examir			treet and number)			4b. City, Town, o		,			unty of Death	
Ĩ.	Funeral Director		011	7. Age	(In yrs. last birti	hday) (rs.	Months Days	If Under: Hours	24 Hrs. 8 Min.	Date of Birtl (Month, Day 05-01	h v, Year) -1935	9. Birthp Coun	place (State or Foreign try) MD
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	he M 88a-f otifie	ecto	MD Anne Aru	ndel	Pa	asa	lena						
	a or	늅	10e. Street and Number				10f. Zip Code	2				of What Coun	Ary?
	eath rs 23 must	eral	1587 Colony Road 11. Marital Status	12. Was Decedent E	ver in II S	13 W	21122		ain? (Specif	hy Vas or No-	U.S.	A. Race - Americ	an Indian
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2X No	Specify:	, Puerto Rio	can, etc.)		Black, White,	
Baltimore, Maryland 21215-0036	d within 72 ho giene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occup ind of work done O NOT use retired	during most d)				of Business/Ind	lustry
7			17. Father's Name (First, Middle, Last)		PI	1010	Engrav:			First, Middle,	Sal		
and	be do la eve	Be C	Bernard Graf							- <i>nsi, widdie,</i> 1 Smeal		name)	
aryi	d 2 should th and Men 7 is marke traumatic	은	19a. Informant's Name/Relationship (Typ	oe. Print)	19b.	Mailing	Address (Street	and Numbe	er or Rural F	Route Numbe	er, City or To	wn, State, Zip	Code)
ž	7 is		Mrs. Evelyn E. Gr				Colony I						,
nore,	of fir		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	1		ition (Name of atory or other place		Date			on - City or To	
ij	# 부 다음 .		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	e M009			e Cremat						remation
ñ	Depa Impo any i		De Alwari)	, –		ervices;				lan Ru	rnio 1	
68760,	Physician / Medical Examiner so the burial-transit	al Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Fall Due to (or as a Unit 1954)	consequence of	ner n: n:		je		1 11 1	rest,	3.166.55	Approximate Interval Between Onset and Death
P.O. Box 687	death cert e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death		Ectopic pregnancy Other (specify)	,			23d.	Date of delive Month	ery Day Year
rds, F	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions con	tributing to death but	not resulting in	the und	derlying cause give	en in Part I.		23e. Did to			ne cause of death?
Division or Vital Records,	The lar ate has page 2	Completed								24a. Was a autop: perfor 1∐ Yes	sy	prior to cor death?	psy findings available npletion of cause of
<u>=====================================</u>	i cian: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	ospital:	44.4		Tout.		of Death (C	Check only or	ne)		
0	Phys this ral dir	٦.	1 Yes 2 No □	1 Inpatient 28a. Date of Injury	t 2 ☐ ER/Outr			4 LJ Nui				Other (Specify)
ision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2	1 15 200	Year) Inj	jury) O	PM 28c. Injur Worl 1 1	y at k? Yes 2□N	No	J U	Ject	Fell	L down stairs
Οį	oltal or Attendurs after death		4 ☐ Homicide determined	building, etc.	(Specify)	or	ne	·	1/3	587 C	OLON	y Rd,	PasadeNa, MD
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical ExamIn	Ician: To the best of er: On the basis of e and manner state	examination and	death /or inve	occurred at the tirestigation, in my o	ne, date and pinion, deat	d place, and th occurred	d due to the o	cause(s) and date and pla	manner as st ce, and due to	ated. the cause(s)
	Tot	2	29b. Signature and title of certifier	Physia:	2n		29c. License	321		2	29d. Date sig	gned (Month, i	Day, Year)
	3		30. Name and address of person who cor		oth (Item 23a) (T			Amb	er R	ollshir	1 MI)	
	Sta	te	31. Date filed (Month, Day, Year) 8 FFB 2 6 2008	32. Registrar	s ilgnatur	A.					1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month EARL, GAINES February 2008 1642 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City Mercy Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□F Days Hours Min 093-56-673 Usual Residence of Decedent June 20,1970 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 No Funeral Director 10 STOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married o, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac þ 3 ☐ Widowed 4 Divorced 'natural", al Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) employ 0 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked o Sonny aura aaines 19a. Informant's N-me/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10550 Gaines Vernon, or other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee Funeral Home, P.A. ve. Batto, Md. 21216 22 WiNorth Ave. Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Syndrome **Physician** Acute Chest Days /Medical Due to (or as a consequence of): Examiner Sickle cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown preumonia. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred NIA Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No NIA within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide NIA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person

FEB26

2008

Khalid A
31. Date filed (Month, Day, Year)

M.D.

rison who completed cause of death (Item 23a) (Type, Print)
A · EI-Sayed , Mercy

32 Registrar's Signature

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2008

tehruary

Medical Center 301 St. Paul Street, Baltimore, ND

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. amend item 30 per dvr 98/6 2-26-08 vt. State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7:50 AM M Albert Ross Hardy February 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 3, 192 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Director 197-18-0239 83 Yrs 1924 New Hampshire Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23e or 28a-f ehow treumatic event, the Medical Exeminar must be notified at MD Montgomery 1 ☐ Yes 2 ☑ No Director Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9531 Veirs Drive #1 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after with Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 3 accountant financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Algernon Sarton Hardy ျှ Emile Ernestine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Hardy/spouse 9531 Veirs Drive #1 Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ites
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of F neral Service Lice ROLL d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Wade ector Baltimore, MĎ en 23a. Part I. Enter the disease, or completations that caused the death. shock, or heart failure. List only one cause on each line. Do not enler the mode of dying, such as carriac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, pluods 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Lwath Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the ! and manner stated 29b. Signature and/title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 20 einsh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh National Lutheran Home 31. Date filed (Month; Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician: completely filled in by the funeral director, page 2 should be detached for use as the burial
Division or	To the Hospital or Attending Phy within 24 hours after death.	To the Funeral Director: After this completely filled in by the funeral or

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner and -transit Medical Certification: To Be Completed by Physician/Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and the of certif 29d. Date signed (Month, Day, Year) 30 Name and address 14 erson who complete "cause of death (Item 23a) (Type, Print) Choke Lane, Baltinore Maiden 31. Date filed (Month, Day, 32. Registrar's Signature Year) State FEB26 Registrar 2008 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 2001 /Medical Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10 3 9. Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours FEB ^h1^{Day}1915 93 213-03-8743 Mary1and Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 □ No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3127 Phelps Lane 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Black ģ 3 ☐ Widowed 4 ₺ Divorced Completed 16b. Kind of Business/Industry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker Steel is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Elizabeth Farley Parley Alexander Ha11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 Phelps Lane, Baltimore, MD 21229 Joyce Ford - Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2/23/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses. Williams 22. Name and Address of Facility of Maryland, Inc. 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 14 /Medical Due to | as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical that the death certificate attending pl IF FFMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1☐Yes 2☐No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ The law requires 2 No 3 Probably 4 Unknown 1 Tes as been signal as a should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autor certificate ha 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

2008

FEB26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** Ha arbaro /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1000500 en If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Hours Min 1□M 200 F Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director HMOSE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 SA 3 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ò 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: If item 27 is marked other that any Injury or other traumarts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 HVE 110 760190 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 27 08 BAUTI MORE 2 Kwood Lemetery! 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Ficility ORD RD. BALTIMOLE 21. Signature of Funeral Service Licenses Frans Funeral Chapela Cremation Services Parkville JM Vei Approximate Interval Between 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No To the Hospital or Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 6 Dother (Specify) Medical Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director; After Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) FEB26 2008

29b. Signature and title of certific



address of person who completed cause of death (Item 23a) (Type, Print)

GHIM

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

les St. bulls. Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Certificate of Death	•	200	0 05700
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	3. Time of Death
	Physici /Medi		Gregory Merideth Hoffmaster	FORMON	1 23, 200	6:30A M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat Additional Property HOSC 141 Raltimore 14	th	4c. County of	Death N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		th s). Birthplace (State or Foreign Country)
	Director		214-72-6995 1XI M 2 F 43 Yrs. Months Days Hours Min.	May 25,	1964 1	Maryland
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	ctor	Md. N/A Baltimore			1 Ves 2 □ No
	vith th	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
,	death with the Maryland me 23a or 28e-f show I must be notified at	Funeral	1330 N. Fremont Ave. 21217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No	USA - 14. Race -	American Indian,
8 9	after or Iter	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Never Married 2 Marned 1 Yes 2 No	to Rican, etc.)		White, etc.
57.5	hours ture!;	d by	3 UNidowed 4 Divorced Year or Dates: X		Specify:	White
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<u>S</u> Σ	and 2 Beith all n 27 to				1d. 21154	
30 ore	Pages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Ci	ty or Town, State
JRKGORY Saltimore, M			4 Donation 5 Other (Specify) Hilltop Service Co. 2-25 21. Signature of Funeral Service Licenses, 22. Name and Address of Facility	i-08	Towson,	Md.
	permit. Depertr Imports eny Inj		Ruck Towson Fun 1050 York Rd. T	eral Hom	ne, Inc. Md. 21204	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heert failure. List only one cause on each line.	c or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			
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	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
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9	entifica ing ph e as th	Medi	IF FEMALE:			
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of Month	
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	res thet igned k be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		ute to the cause of death?
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Rec	has to	Completed		24a. Was autop	an 24b. We priced? dea	re autopsy findings available or to completion of cause of ath?
tal	icien: The certificete hi ector, page	Be Co	25. Was case referred to medical 26. Place of De-	1 ☐ Yes	2 ₩No 1 □]Yes 2□No
Ž	Physici this cer at direct	To B	examiner? 1 Yes 2 No			(Specify)
ט עמ	ding Ph h. After th funerat		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?		now injury occurred	
risio	Attendi death. octor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number	or Rural Route Number.
á	s after of Dire	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tov		
	To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the basis of examination and occurred at the basis of e	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number	-11	29d. Date signed (Wonth, Day, Year)
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ì	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	HOST	pital	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- Sp		
	Registr	ar	FEB 2 6 2008 Some & park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 09:41 February 3008 22 /Medical 4c. County of Death b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstone Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218.44.075 Months Days Hours 1□ M 2 KF MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylar Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 ☐ Yes 2 No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) OF Department College (1-4or 5+) Elementary/Secondary, (0-12) Surveyor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geome Johnson vanacline Thomas 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Pural Route Number, City or Town, State, Zip Code) ehnert Street 6518L GWYNN Oak MD 21207 Daughter Shrannon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cremator 26/08 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility Vaughy C. Greene Fluneral Services Randallstown MD 21/33 8728 Liberty Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform 1□ Yes 2▼No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes No the receiver within 24 hours after death.

To the Funeral Director. After this of the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 46055644 ,66 rebizuary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Hospital 5401 Old Covert Rd. Randall stown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB26

ORIGINAL

	_	-	For State Registrar			Certificate of	Death		eg. No. 2008	05734
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat	Day Year	3. Time of Death 12:09 P •M
	/Medic	al 🗉	Norman H. Hilderbra 4a. Facility Name (If not institution, give sti			4b City Town o	r Location of Death	Feb. 21,	4c. County of Death	
	Examin	er	Washington Adventis			Takoma Pa	_		Montgomer	
-	Funeral		Social Security Number 6. Sex	7. Age (In yr	,		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	pplace (State or Foreign
ļ.	Director		219-12-3131 Usual Residence of Decedent	8	4	113.		Oct. II	, 1923 Mary	rand
	/land low at		10a. State 10b. County	10c. C	City, Town	or Location				10d. Inside City Limits
	a-f sh iffied	ctor	Maryland Prince Geo	orge's Col	.lege	Park				1☆ Yes 2 No
	or 28)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	•
	ath w	rall	8511 48th Avenue			207		sit . Van an Na	United Sta	
	item:	Funeral Director	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in Armed Forces? 1 XYes 2 No 	0.5.	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto F	Rican, etc.)	Black, White	
5	ırs afi al', or xami	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates: 1943	-46	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
2-003p	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	eted	15. Decedent's Educa (Specify only highest grade	tion completed)	16a.	Decedent's Usual Occup	ation during most of workir	ng I	16b. Kind of Business/I	
Z	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "natural", or items 23a or 28a-f showed other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sho	(Give kind of work done life. DO NOT use retired et Metal Wo		.5	of Health	iscicates
7	iled w Hygiel ther ti nt, th		17. Father's Name (First, Middle, Last)		Dire	et Hetal wo	18. Mother's Name			
yland	2 should be filed and Mental Hygie is marked other aumatic event, the	o Be	James Henry Hilder	orand			Virgie Be			
	should and Men s marke umatic	욘	19a. Informant's Name/Relationship (Type		19b.	. Mailing Address (Street				ip Code)
Mar	12 mg g		Charles H. Hilderb			020 Suffolk		Gaithe	rsburg, MD	20878
e C	es 1 a of Hea fitem rrothe		20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3 □ Re	20b	. Place of cemeter	Disposition (Name of ry, crematory or other place			20c. Location - City or	
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)		klawn	Memorial Park			Rockville,	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensed	моов9	96	Robert A.	Pumphrey I tgomery Av	Funeral ve., Roc	Home/Rockv kville, MD	ille, Inc. 20850-2805
	15/3		23a. Part1. Enter the disease or comilio shock, or heart failure. ist only one							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		e 05	b				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons		•				
	LXAIIIIIIEI	7	Sequentially list conditions, b.	Due to (or as a cons		no hia				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Acade &		piratry ,	failure			
,	execu n and ial-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a cons	equence	of):	, , , , ,			
68/60	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		d.							
	ng ph	Med	IF FEMALE:	11122						
Š R	leath cer attendin I for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pred 1☐Live birth 2☐F	etal death		y		23d. Date of del Month	very Day Year
	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	r death	5 ☐ Other (specify) _				
1	that t led by detac		Part II. Other significant conditions cont	ributing to death but not r	esulting in	n the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
g	quires n sign ald be	d by						1 □ Y	es 2. No 3⊟Pr	obably 4 □Unknown
ecords,	aw require	Completed						24a. Was a		topsy findings available completion of cause of
Y		No.						perfor		
VIta	clan: ertifica	Be (25. Was case referred to medical examiner?			Tou	26. Place of Death	(Check only or	ne)	
5	Physi this c al dire	ျ	1 ☐ Yes 2 ☐ No	ospital: 1 Impatient 2 28a. Date of Injury	□ ER/Ou	itpatierit 3 LOA			ence 6 Other (Spe	cify)
u O	ding I	tion:	1 ✓ atural 5 ☐ Pending	(Month, Day Year,		Injury Wo	rk?]Yes 2 □ No	Log. Describe n	ow injury occurred	
DIVISION	l or Attend after death Director: /	Certification:	3 Suicide 6 Could not be	28e. Place of injury - A	home, fa	arm, street, factory, office	-		Street and Number or Ru	ıral Route Number,
S	s after	Serti	4 ☐ Homicide determined	building, etc. (Spe	есту)			City or Tow	ni, State)	
	To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director.	edical (29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examin	ician: To the best of my ler: On the basis of exam	knowledge ination ar	e, death occurred at the t nd/or investigation, in my	ime, date and place, opinion, death occurr	and due to the ored at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.	L A	H MED 29c. Licen	se number	2	29d. Date signed (Mont	h, Day, Year)
	F S F Ö		A in	0	~ 1	00	06010	0	02-22-	08
7	0+1		30. Name and address of person who con	npleted cause of death (I	tem 23a)	(Type, Print) TA	Hm IN A	16	AGMED	903
	V 1 .	ate		32. Registrar's Signal	gnatur	Some has	CF 51100	3/2/	V11) 20	
	Regist		31. Date filed (Month, Day, Year) FEB 2 6 20	108 Alexan	15	157				

7:50 Pm

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes XXNo

Approximate
Interval Between
Onset and Death
Admitted

2/14/08

Expired

2/22/08 at

7.15 pm

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23d. Date of delivery

2/23/08

Maryland

14. Race - American Indian Black, White, etc.

Specify: White

Fabracator

State Registrar

JUMANI, M.D SATISH 31. Date filed (Month, Day, Year) FEB 2 6 2008

mani.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 St. Patricks Drive, Svik 208, would ort MD 20603 32. Registrar's Signature

M.D.

D 35295

PATIENT HNOWN AS DEDN HARVEY Baltimore, Maryland 21215-0036

		Please T	ype or Print in Blac					
		For State	State of Maryland / [1ental Hygie	ne	the first own and the
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death 	Reg. 2. Date of Death	No. 2	3. Time of Death
Physici /Medic		Deon B.	Harvey			Feb	18 200 8	1127 PM
Examin		4a. Facility Name (If not institution, give s			r Location of Death		4c. County of/Death	
Funeral		5. Social Security Number 6. Sex	OF BALTIMON		NONE C	8. Date of Birth	9. Birthr	place (State or Foreign
Director		212-45-4036 1	M 00 5 1 6	Yrs. Months Days	Hours Min.	May 31	1995 M	
land bw It		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location			1	0d. Inside City Limits
a-f sho	ctor	Md. NA	Ba	Himore				1 XYes 2 □ No
vith the	Director	10e. Street and Number		2nd 10f. Zip Code	مسرة	10g.	Citizen of What Cour	ntry?
flied within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or Items 23a or 28a-f show but, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	2.75 Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Americ	an Indian,
after or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2⊠ No If Yes, Give	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc.
hours tural", al Exa	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			10	Specify: B	lack
be filed within 72 ha ntal Hygiene. od other than "natu event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Give kind of work done life. DO NOT use retired	during most of work		o. Kind of Business/In	dustry
filed within Hygiene. other than rent, the M	Com	6	00000	Stude	nt		Scho	0
d be fill intal H ed oth	Be	17. Father's Name (First, Middle, Last)	Harva		18. Mother's Name	e (First, Middle, Mai	den Surname)	_
should and Me mark umatic	입	19a. Informant's Name/Relationship (Type	pe. Print) Futher 19b	. Mailing Address (Street	and Number or Run	al Route Number, C	ity or Town, State, Zip	Code) 2121
purmit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic events.		Mr. Rodney 1	tarvey 3:	541 Reis	terstor		Floor Bal	to.Md.
ages 1 nt of H if iter or oth		20a. Method of Disposition ∫ 1 N Burial 2 □ Cremation 3 □ R	cometo	Disposition (Name of ry, crematory or other place	ce) 2/5	Date 200	c. Location - City or To	own, State
nit. Pa artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	V(7	22. Name and Addre	ss of Facility	12008	ansao.	wne, Ma.
Deparent Portrain Deparent Portrain Por		Saroph o	L. Russ	Joseph L	RYSSAF	uneral	Home Pif	16
		23a. Part1 Enter the rease, or compli- shoot, or heart fall re. List only on	cations that caused the death. Do not cause on each line.			or respiratory arrest		Approximate Interval Between
Physician /Medical		Immedia e Cause (Final disease or condition resulting in death)	DIABETIC	KETOAC	IDOSIS			Onset and Death
Examiner		1 .	Due to (or as a consequence	01):				•
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
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death certificate be attending physicie d for use as the bu	Medi	IF FEMALE:						
ath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		y		23d. Date of deliver	ery Day Year
t the de by the	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	5 ☐ Other (specify) _				
The law requires that the death certificate be to has been signed by the attending physicia bage 2 should be detached for use as the bur	by P	Part II. Other significant conditions con	tributing to death but not resulting in $\mathcal{N}\mathcal{N}\mathcal{E}\mathcal{N}\mathcal{T}$ $\mathcal{D}\mathcal{A}$		_		co use contribute to the	
requir	Completed	THOULIN DETE	NOEN DIR	DEICS IN	ELLITUS	-	2 No 3 Prob	
he law e has l	mp					24a. Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
	0	25. Was case referred to medical			26. Place of Deat	performed 1 Yes 2 x	No 1 ☐ Yes	2□ No
ding Physician: n. After this certific funeral director,	To B	1 103 2 100	ospital: 1 Inpatient 2 FR/Ou		er: 4 ☐ Nursing Ho		e 6 □Other (Specif	(y)
ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of 28c. Injur njury Wor M 1 □	yat k? Yes 2 ⊡No	28d. Describe how	injury occurred	
Atten or deat ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, far			28f. Location (Stree	et and Number or Rura	al Route Number,
ital or irs afte rat Dir iled in			building, etc. (Specify)			City or Town, S		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, the funeral director director, the funeral director director, the funeral director dir	Medical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examir	ician: To the best of my knowledge ner: On the basis of examination an and manner stated.	, death occurred at the tird d/or investigation, in my o	me, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month,	
		· Amictay	ma	DOO	48164		Feb 19	12008
M		29b. Signature and title of certifier AMULTA 30. Name and address of person who co AHMET AYS A 31. Date filed (Month Pay, Chap) 200	mpleted cause of death (Item 23a) (Type, Print)	AC RA	14 mar		
Sta	te	31. Date filed (Month Pay, deap) 200	8 3 Registrar's Signature	A SPITAL	of ou	איטוויו	-	
Registr	ar	FED 4 U Zuo		4				

Registrar

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FÉBRUARY DZ1 2008 MARY E. JACKSON 9:56A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death RANDALLSTOWN NORTHWEST HOSPITAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/14/1938 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 220-36-6718 1 M 2 K F 69 Months Days Hours Min. MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State BALTIMORE MD PIKESVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8122 STREAMWOOD DRIVE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL NURSE MEDICAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM GAITHER FANNIE MADDOX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILBERT R. JACKSON / HUSBAND 8122 STREAMWOOD DRIVE, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MD VETERANS' CEMETERY GARRISON FOREST 1 Burial 2 □ Cremation 3 □ Removal from State 02/27/08 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD se, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. ock, or heart failure. Imme at ause (Final disease or condition resulting in death) CAMDIAC Due to (or as a consequence of): Sequentially list conditions Due to for sea a no cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Νo 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA 28b. Time of 27. Manner of Deat 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident

death certificate be executed and -trar physician ar Box 68760. attending p P.O. I signed by the a Division or Vital Records, been si has e 2 page or Attending Physician:

Examiner Physician/Medical Completed To Be

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

6

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of Health and Mental Hygiene.

Pages 1 and 2 should be 1

Department of important; if it any injury or c

Physician

/Medical

Examiner

event, the Medical

within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

ģ

Completed

Be

2

certificate Certification: 24 hours after death.

Funeral Director: A etely filled in by the fu death. Medical

Hospitai within 24 l

Registrar

CHARLES 31. Date filed (Month, Day, Year)

FEB 26

29b. Signature and title of certifier

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

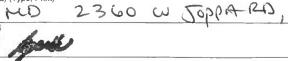
6 Could not be determined

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D52313

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 3:30 PM Kichard Jones 20 2008 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville 123 Cherrydell Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F Months Days 9, Director 1937 70 Connecticut 040 30 1413 Oct. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show 1 ☐ Yes 2 No Catonsville Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be in 21228 USA 123 Cherrydell Road filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sales Associate permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Jones Marie Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William H. Jones, III 4530 6th Place SW; Vero Beach, FL 32968 Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2-26-2008 Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Se Me 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Cerebrovascular **Physician** /Medical Due to (or as a consequence of): Examiner abetes Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-transit Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 2 No 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 1No 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Medical 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of of tifier 29d. Date signed (Month, Day, Year) 12008

State Registrar

DHMH 17 Rev 1/2001

tranz

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sewc

700 Geipe Rd Catonsville, MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				State of Maryland / Dep. 24a per verb., 2876			Mental Hygi		05739
ž	Physici	ian	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death 456 PM
	/Media	cal	Joseph Gerard Kea 4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Death	Hebruary	4c. County of Deat	
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	yland		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar Find	tor	MD harford	Bel A	ir				1 □ Yes 2√√ No
	be filed within 72 hours atter death with the Maryland ital Hygiene. id other than "natural", or Iteme 23a or 28a-f ehow event, the Madinal Exprine must be mailfied at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
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	teme teme	Funerai	11. Marital Status unk	12. Was Decedent Ever in U.S. Amed Forces?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	hours atter tural', or Ite	by Fi	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
9500-61212	hour fural	pa pa	15. Decedent's Edi		dent's Usual Occupa	ation	1	6b. Kind of Business/	Industry
Ċ	within 72 ene. than "nat	piet	(Specify only highest grad	le completed) (Give	kind of work done d DO NOT use retired;	lurina most of work	ting	ob. King of bosinosa	madatiy
7	i with	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)	bake	r		food indu	stry
and	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
<u>a</u>		ToE	Joseph Charles Ke	earney		Clara B	arbara Ma	aisch	
Mar	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T	vpe, Print) 19b. Maili	ng Address (Street a	and Number or Rui	al Route Number,	City or Town, State, 2	Zip Code)
e, ≥	and and n 27 m 27		Kathie Rohfling/d		Florio Dr				
0	ges 1 t of H if Iter or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 DI	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place		Date 2	Oc. Location - City or	Town, State
	tant:		4 ☑ Donation 5 ☐ Other (Specify,						
Baltimor	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Emeral Sories Alcens			_		Baltimore	Street
Ä.			23a Part 1 Foter the disease or comb	ications that caused the death. Do not en	altimore,			st .	Approximate
			strock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.			5 W	,	Interval Between Onset and Death
	Pri ysicia n /Medical	1	disease or condition resulting in death)	a. A CUTE MYOCA Due to (or as a consequence of):	RDIAL	INFARC	110N		
	Examiner			Due to (or as a consequence or).					
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o	be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):					
2/60	e ys	icai		d					
20	death certificate t ettending physic I tor use as the b	Med	IF FEMALE:						
X D	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy			23d. Date of del Month	ivery Day Year
5	the	Physician/M	1 Yes 2 No	4□Pregnant at time of death 5[9□Unknown	Other (specify)				,
7.	that the ed by detacl	P.	-	ntributing to death but not resulting in the u	inderlying cause give	an in Part I	23e, Did toba	acco use contribute to	the cause of death?
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d)	The law i ate has by page 2 sh	E G	CARDIOMYOPATA	Y, SEVERE AORT	16 SIEN	05/-5/	autopsy perform	ed? death?	topsy findings available completion of cause of
	sician: The law certificate has b irector, page 2 s	e Co	25. Was case referred to medical	DYSCIPIDEMIA		GC Diseased David			2 No
>	itsading Physician: Jeath. tor: Atter this certific the tuneral director.	0 8	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Othe		th (Check only one	nce 6 □Other (Spe	coft()
	g Phy erthi eral⇔	ļ.	27. Manner of Death	28a. Date of Injury 28b. Time of			28d. Describe hov		Oi,y)
DIVISION	Attending r death. sctor: Atter	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		res 2 □No			
<u>s</u>	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri	ural Route Number,
ב	ital o irs aft ral Di	Certification:							
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	Medical	(Check only 2 Medical Exam	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in	th occurred at the time	e, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c. License			d. Date signed (Mont	
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			SURESH DHANT	ompleted cause of death (Item 23a) (Type, MI MD 6 2 2 5. (32. Registrar's Signature	MILALA AL	IC HAIL	00 >50	DACE M	X 2/078
100	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ARIUN HV	e, mil	L DE 41	MICK, I'M	521010
- A	Registr		EER 2 6 2008	Market M. Asses	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2008 **Physician** February Regina F. King 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 8, 1954 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours 53 214-66-5468 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7016 Park Heights Avenue, Apt C1 21215 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles King Retha Mosby ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chaunce King, Son 4000 Fords Lane, Apt.2A Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 02/26/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 Min Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular Tachycardia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dilated Cardiomyopathy 24a. Was an autopsy performed Yes 22 No 1□ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred . After Injury safter dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a To the Funeral I To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date and place and place and place, and due to the cause(s) and manner as stated. 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0021730 February 24, 2008 30. Name and address (f person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Avenue Baltimore, Maryland 21215 Tariq Khan 31. Date filed (Month, Day, Year) 32. Progietrar's Signature State FEB26 2008 Registrar aceur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Franklin Kyte Russell 1433 1 February 24 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 8. Date of Birth (Month, Day, Year) October 25, 1952 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 📈 2 🗆 F Months Davs Hours Min. 55 Maryland 214-54-6793 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits N/A Baltimore 1 X Yes 2 □ No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21212 USA 201 Homeland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Assistant 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Loraine Campbell James Benjamin Kyte Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1826 Kinship Road, Dundalk, Maryland 21222 <u>Lola Doby</u> sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 25, 2008 Baltimore, Maryland Bayview Crematroy 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 omplications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final neumonia days disease or condition resulting in death) Due to (or as a consequence of): Obstructive Pulmonary dz cequentiary list conuncins, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lespiratory Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 ☐ Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 NO 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical **Examiner** The law requires that the death certificate be executed burial-transit

and

has been signed by the attending physician je 2 should be detached for use as the buria

page

funeral director,

filled in by

Medical

After this

Hospital or Attending Pl 4 hours after death. Funeral Director: After t

24 hours a Hospital

within 24

Division or Vital Records, P.O. Box 68760,

Physiclan:

permit. Pages Department of Important: If It any injury or o

Physician

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Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notifled at

Item 27 is marked other than "nature other traumatic event, the Medical

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Funeral

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Completed

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the Maryland

2 should be filed within 72 hours after death with a nand Mental Hygiene.
Is marked other than "natural", or items 23a or?

Pages 1 and 2 s ment of Health an Health tem 27

3altimore, Maryland 21215-0036

Examine Physician/Medical Completed Be 스 Certification:

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3 ☐ Suicide

4 Homicide

29a. Certifier

6 Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Memorial Hospital

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, State

32. Registrar's Signature Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

			Plea	se Type or Pri							_		_	ble.	
			For State Registrar	State of Ma	aryland		rtment <i>tificate</i>			and M	ental H	ygien Reg. N	6	008	05742
	D		1. Decedent's Name (First, Middle	e, Last)							2. Date of D	eath Da	av	Year	3. Time of Death
	Physicia /Medic		Russell	Lee		Kavana	augh				Februa		24_	208	250 AM
	Examin	-0.630	4a. Facility Name (If not institution	00 11			4b. City, To	own, or l	Location of	of Death		4	c. County	of Death	n
1			5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1		If Under	24 Hrs	8. Date of E	lirth		0 Dietl	nplace (State or Foreign
.Sa.	Funeral Director		217-77-5368	1. XM 2□ F	1		Months I	Days 10	Hours	Min.	January	Day, Year		Co	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						_		10d. Inside City Limits
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	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. V	Was Decede	nt of His	spanic Ori	gin? (Spe	cify Yes or h	10-		ce - Amer	nican Indian,
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72	withi iene. than the M	Completed	Elementary/Secondary (0-12) 0 years	College (1-4or !	5+)		N/A	,					I/A		
2	be filed within 72 hours after death with the Maryland tral Hygiene. Id other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Midd	le, Maide	n Surnai	me)	
<u>Ja</u>		To B	Richard Kavanau	gh					Rox	anna	Crous	e			
Maryland 21215-003	and sum		19a. Informant's Name/Relations			1					al Route Nun	_			
	and ealth n 27 ner tr		Richard & Roxanna K	avanaugh Pare											d 21220
0	Pages 1 Tent of H Int: If iter		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 ☐Removal from State	CE	lace of Dispo emetery, cren View (natory or oth	ner place	7	ebru	_	,		-	Town, State
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Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	11. Sul	1001	()a 1 Cc	onnell	ŷFi	inera	l Ho	me Of Road,	Dunc	lalk,	P.A.	21222
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	Dhysician		shock, or heart failure. List Immediate Cause (Final	only one cause on each II	ne.	V +									Interval Between Onset and Death
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	Examiner			TO	MON										Bokeys
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as						,				i di	_
1	xecuted and I-transit	xamine	Cause (Disease or injury that initiated events resulting in death) Last	a. Hout		Nyelo	FENCL	5_	Lei	UKE	Ma				6 motiths
20,		ш	resulting in death) Last	Due to (or as	a consequ	ience of):	•								
68760	ficate be ex physician s the burial	dica		d											
	death certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	pf pregna	ncy							23d D	ate of del	iven
Box	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pred Other (spe					_		onth	Day Year
o.	the day the ached	Physician/Medical	9 ☐ Unknown	9□Unknown											
S,	as the	by PI	Part II. Other significant condition	ons contributing to death t	out not resu	ılting in the ur	nderlying cau	use give	n in Part I				,		the cause of death?
Records,	w require been sign	ed									1[] Yes	2 4 No	3 □ Pr	obably 4 Unknown
ပ္ပ	law r las be	Completed									24a. W	topsy		prior to	utopsy findings available completion of cause of
_	ding Physician; The lav n. After this certificate has funeral director, page 2	Con									pe 1□ Yes	rformed?	16	death? 1 ☐ Yes	
Vital	sician; The certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	r.		n (Check onl				
ō	Phys this ral dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time of		`	4 🗆 191		me 5 Re 28d. Describ				cify)
O	dlng h. After fune	tion	1 □ Natural 5 □ Pendir 2 □ Accident investi	ng (Month, Da	ay Year)	Injury	М	lc. Injury Work	? ⁄es 2 🔲						
Division or	Atten r deat ector:	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of in	jury - At ho	me, farm, str	reet, factory,	office			28f. Location	(Street	and Num	ber or R	ural Route Number,
á	s after al Dire	Certification:	4 Homicide determ	building, e	tc."(Specify	/)					City or	Γόwπ, Sta	ite)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical (ng Physician: To the best Examiner: On the basis of and manner st	of examinat										
	To th Within To th COMP	Ň	29b. Signature and title of certifie	0 0			29c.		number				_		h, Day, Year)
)			I Com (fe	whichy mi)		D	38	127			Fe	bro	1/15	24,2008
			30. Name and address of person				Print)	0	Ц.		^	<u> ا</u>	, ,		24,2008
	17		31. Date filed (Month, Day, Year)	Ders mo	rar's Signa	ture Time	Cel	130	mm.	DE 1	11 pay	ranc	1 2	an	
	Sta Registr		FEB 2 6	2008	1		MOR.								
			LUNG			13									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	1- State of Maryland / Dep Registrar Ce	artment of Health and Martificate of Death	lental Hygie	ene . No. 0 0 8	05743
	Physici	an	1. Decedent's Name (First, Middle, Last) Lorraine V. Keefer		2. Date of Death Month	3, 2008 Year	3. Time of Death 2:00 AM
	/Media	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February 2	4c. County of Death	
	Examir	ier	Franklin Woods	Rosedale		Balt irore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
	Director		218 – 36 – 1 5 1 7 1 M 2A) F 88 Yrs. Usual Residence of Decedent		March 6,	1919 Mary	yland
	yland how		10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	h the Marylan r 28a-f ehow notified at	ctor	MD. Baltimore Parkvi				1 ☐ Yes 2X No
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow the Madical Examinar must b. motified at	Funeral Director	10e. Street and Number 3916 Tila Road	10f. Zip Code 212 34	100	g. Citizen of What Cou USA	ntry?
	death me 23	eral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
õ	d within 72 hours after death with giene. r than "natural", or Iteme 23a or the Medical Examiner must be.		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White Specify: Whit	
215-0036	hours tural',	ed by	3 Mildowed 4 Divorced Year or Dates:	edent's Usual Occupation	16	Sb. Kind of Business/Ir	
<u>ر</u> ت	hin 72 In "na Medic	Completed	(Specify only highest grade completed) (Giv.	e kind of work done during most of work DO NOT use retired)	ing	At Home	idustry
7	filed witl Hygiene other the	Com	6	omemaker 			
Maryland	m	Be	17. Father's Name (First, Middle, Last) Albert York	18. Mother's Nam. Mary M.	e (First, Middle, Ma . Holzhur	iden Surname)	
ary	should be and Mental s marked o umatic eve	P		ing Address (Street and Number or Run		City or Town, State, Zi	p Code)
	and 2 lealth a m 27 li			4 Cicero Pkwy.		•	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic a <u>once.</u>		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	ed Methodist 02	28/08	Fork, MI	
alt	mit. P partme sortan y injur		Then C	emetery 2 Name and Address of Facility Evans Funeral C		Cromati	an Contrions
ñ	e d E e d	1	Jargulin Erais	8800 Harford Rd	. Parkv	ille, MD	21234
			23a/. Part I. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. 2 4 5 v C Due to by as a consequence of):	neart tail	ire		
	Examiner	ı					
	pe IIs	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
_15	be executed ician and burial-translt	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
20	ate be executed hysician and the burial-transit	ical	ø				
D D X	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:				
X D D	eath c	cian/	In the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
j.		hysk	1 ☐ Yes 2 ☐ No 4 ☐ Fregriant at time of death 5 in 9 ☐ Unknown 9 ☐ Unknown				
ν, T	requires that the der neen signed by the a hould be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
cords	req eer	eted	Chronic renal tailure		1 Tes	2 1No 3 Pro	bably 4 □Unknown
(D	e law has b	Completed			24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
		မ လ	25. Was case referred to medical	26 Place of Deat	1 Yes 2	SNo 1 □ Yes	2 No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ M6 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other		ce 6 □Other (Speci	fy)
			27. Manner of Death 1 ☐Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how		
VISION	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or Rur	ral Route Number,
2	s after s after al Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify)	,	City or Town,	State)	
)	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, dea 2☐ Medical Exeminer: On the basis of examination and/or in and manner stated	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as	stated. to the cause(s)
	To the I	Mec	one) and manner stated. 29b. Signature and title of certifies	29c. License number	290	I. Date signed (Month)	Day, Year)
	, , , , , ,		700 Elmondon MA	D45766	F	houns!	23 2008
À	7		30. Name and address of person who completed cause of death (Item 23a) (Type	D45766 lin Square Driv	0:	Direction	~ ~
7			Jon Edmond Son MD 115 Frank 31. Date filed (Month, Day, Year) 32. Registrar's Signature	In Square briv	e, Ste. 310	Dath mi	re MV 2/23/
	Sta Registr		EFR 2. 6 2008	A CONTRACTOR OF THE PARTY OF TH			
				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month
FEDRY Pay 27
4c. Couply of Death **Physician** ING 2008 SAN /Medical 4b. (Tw., Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner C412d4/14 Monthway If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 226.76.7953 1 ☐ M 2 F Yrs. 57 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. It was a few 23a or 28a-f show then 77 is marked than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 XNo MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number INSA Carlswood 21244 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Northwest Hospital ntary/Secondary (0-12) College (1-4or 5+) Unit Clerk 12th grade 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbert Trusgo annon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m Wayne S. Circle Baltimore MD 21244 3256 Carlsmood Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State Woodlawn, MD 03.01.08 injury Woodlavan Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Acility Vaugun C. Greene Tuneral Senice 21. Signature of Funeral Service Licensee Road Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Officer significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has page 2 autopsy performe this certificate 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Deat

1 Natural

2 Accident funeral 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: (Month, Day Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ess of person who completed cause of death (Item 23a) (Type, Print) Road, Randallstown 019 cunt STEVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 6 2008 Registrar

		1	_ State	of Maryland / Dep	partment of He		ntal Hygien		الله والمالية
	Physicia	an	1. Decedent's Name (First, Middle, Last) Mary A. Klarman			2.	Date of Death	Day Year 27. 2008	3. Time of Death 2:20 A M
	/Medic Examin		ta. Facility Name (If not institution, give street and Union Memorial Hospi			ocation of Death		c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 🛣	7. Age (In yrs. last birthda 81 Yrs.		If Under 24 Hrs. 8. Hours Min. 5	Date of Birth (Month, Day, Yea - 23 -	tr) Count	ace (State or Foreign ry) consin
	Maryland -f show led at		Usual Residence of Decedent	10c. City, Town or Bal	Location timore			10	od. Inside City Limits XXYes 2 □ No
	h with the 23a or 28a st be notii	al Director	10e. Street and Number 830 W. 40th Street		10f. Zip Code	21211	10g. (Citizen of What Count	ry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If them 27 is marked other than "natural" or items 23a or 28a-f show If item 27 is marked other than "natural" or items 2a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes	es 2XXIo	3. Was Decedent of Hisp If Yes, specify Cuban 1 ☐ Yes 2010	panic Origin? (Specifo , Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, e Specify: Wh	
Maryland 21215-0036	hin 72 hour e. an "natural' Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade complet	ed) (Gi	cedent's Usual Occupative kind of work done due. DO NOT use retired)	ring most of working		Kind of Business/Ind	
ind 21;	be filed withi ital Hygiene. d other than event, the M	Be	17. Father's Name (First, Middle, Last)	5+ Depu	ty Chair of Epidemiol	8. Mother's Name (F		•	ns
Maryla	d 2 should be filed w th and Mental Hygie 7 is marked other t traumatic event, th	<u>م</u>	Louis P. Monk 19a. Informant's Name/Relationship (Type. Print) Dorothy Johnson S:		ailing Address (Street an Cedar Road	nd Number or Rural F	loute Number, Cit		Code) 21146
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition ★XBurial 2 □Cremation 3 □Removal fr	20b. Place of Dis	sposition (Name of crematory or other place wn Memorial	Date	e 20c.	Location - City or To	
Baltii	permit. I Departm Importar any Inju		21. Signatur Funeral Service Licensee	,	22. Name and Address Burgee-Hens 3631 Falls	of Facility SS—Seitz F Road Ba	uneral H ltimore,	ome, Inc. Maryland	21211
,	cate be executed Medical Examiner into burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	at caused the death. Do not on each line. STAGE LHRU to (or as a consequence of): to (or as a consequence of):				Y DISEASE	Approximate Interval Between Onset and Death
P.O. Box 687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive	ery Day Year
	aw requires that t s been signed by ? should be detac	by	Part II. Other significant conditions contributing	to death but not resulting in th	e underlying cause giver	n in Part I.	23e. Did tobace	co use contribute to the	/
l Reco	The law reate has bee page 2 shou	Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	_/	Othe	26. Place of Death (
ō	g Physer this eral di	To To	27. Manner of Death 28a. I	1 ☑Inpatient 2 ☐ ER/Outpa Date of Injury 28b. Tim Month, Day Year) Inju	e of 28c. Injury	4 Indising Home	d. Describe how i	e 6 Other (Special injury occurred	у)
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. F	Place of injury - At home, farm building, etc. (Specify)	M 1 □ Y	es 2 No	f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital within 24 hours at To the Funeral Completely filled	Medical Ce	(Check only 2 Medical Examiner: On	o the best of my knowledge, d he basis of examination and/o manner stated.					
	To the within 2 To the comple	Me	29b. Signature and title of certifier Hymmyy ; 1	иО	29c. License AT 24		1	Date signed (Month, bruary 2)	-
_	19	Į į	-	NZON, MD					
	St. Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 6 2008	32. egistrar's Signature	fort				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 98/6 2-26-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Barbara M. Kees $_{A}^{M}$ 25 12:55 Feb. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M Yrs. 87 June 8 1921 Director 216-44-2201 NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notifled at 1 ☐ Yes 2 ☑ No Director MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21152 USA 2323 Tracey Rd. "natural", or items 23a Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ð 3 ☐ Widowed 4 ♥ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Horse Trainer Horse Training traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Ments ant: If item 27 is marked William Williams Marion Williams 13b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Rudolph/daughter Tracey Rd., Sparks, MD 21152 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2/26/08 Catonsville, MD 21. Signatur Heral Pervise Licenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ္ပ 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 ☐ Homicide within 24 hours a

To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 5205 con

DHMH 17 Rev 1/200

State Registrar

6701

32 Registrar's Signature

Charles St balts. Md 2:20x

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 8:37 A M Feb 20, Nelle Ragan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6520 Rosemont Street Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Hours 1 M 2 G F 412 28 4005 Tenn July 23, 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2☐ No Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6520 Rosemont Street 20772 United States Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√√ No If Yes, Give A.A. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 🎀o Specify Specify: 3 XVidowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Statician Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gordon N. Ragan Lura Reece 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Clark (POA) 6520 Rosemont St, Upper Marlboro, MD 20772 Feb 25, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Fort Lincoln Cemetery Mausoleum Brentwood, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) (or as A) onsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical **Examiner**

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental hygiene. and the first 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed sician and burial-trans physician s the buria attending p been signed by the should be detached page 2 s has certificate To the Hospital or Attending Physician: director, this

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner Be Completed by Certification: To within 24 hours after death.

To the Funeral Director: Af

dica	d									
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ½D No 9 □ Unknown ¹	23d. Date of delivery Month Day Year								
β	Part II. Other significant conditions co	ouse contribute to the cause of death? 2								
Completed					24a. Was an autopsy performed 1∐ Yes 2√2					
To Be (25. Was case referred / medical examiner?	e 6 □Other (Specify)								
	27. May er of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, street, factify)	28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical ((Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
ž	29h Signature and little of sertifier	10		29c. License number	29d.	Date signed (Month, Dav, Year)				

29d. Date signed (Month, Day, Year)

State Registrar 29b. Sign

30. Name and addless of person who completed cause o

death (Item 23a) (Type, P(int)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depar

rtment of Health and Me	ntal Hygiene?	05748
ificate of Death	Den No	00170

					Ce	rtificate of	f Death		Rag. No.	O O	00170
			1. Decedent's Name (First, Middle, La		10-			2 Date of De		Veer	3. Time of Death
	Physici /Medio		WILLIAM N	MICHAEL	KESE	LKER		Month	23	Vear 05	1141
1000	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	or Location of Death	4c. County	of Death	
			Tate Hospice	House			Linth	icum	Ann	e Ar	unde1
	Funeral			Sex, 7. Age (In	yrs. last birthday)	If Under 1 Yea Months Days			th y, Year)	9. Birth	place (State or Foreign intry)
	Director		578-82-7958	19€M 2□ F 45	Yrs.			07-05-			hington D.C
	pu 🗶		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	neation					10d. Inside City Limits
	shor	5			. Ony, rount of Ed						1 ☐ Yes 2X No
	he M	Director		Arundel			nton		10g. Citizen of V	What Cou	unto/2
	be filed within 72 hours after death with the Maryland stal Hyglene. do other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at	ក្ដ	10e. Street and Number			10f. Zip Code					
		Funeral	546 Retreat Ct.	Apt. D 12. Was Decedent Ever	in II C 12	Man Donadant of	21113	(Specify Vos or No	United		ican Indian,
	Ter de	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	110,3.	If Yes, specify Cu	iban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Blac	k, White,	
20	rs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X N	o Specify:		Specify	: 1,11	hite
Ş	tural	8	15. Decedent's E		16a. Dece	dent's Usual Occ	upation		16b. Kind of Bu		
21215-0020	- 6	Completed	(Specify only highest gi	rade completed)	(Give	kind of work don DO NOT use retir	e during most of t	working			
212	should be filed within or and Mental Hygiene. markad other than or matic event, the Mad	E	Elementary/Secondary (0-12)	College (1-4or 5+)	E	lectric	ian		E1e	ctri	ca1
ਰੂ	Hygi Hygi other ent, t		17. Father's Name (First, Middle, Las	t)			18. Mother's N	Name (First, Middle	Maiden Suman	Θ)	
au	Mental Mental arkad o	To Be	Robert J. Kese	ocker Sr			E11	en N. Coy	1e		
žζ	d 2 should th and Men 7 Is marka traumatic	Ė	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stre		Rural Route Numb		State, Zi	ip Code)
ž	7 18 at 1		Ellen N. Kesecker	r / Mother	516	Meadowm:	ist Wav	Odenton,	Marv1a:	nd 2	1113
ē,	Pages 1 and 2 tmont of Health tant: If Itam 27 I jury or other tri		20a. Method of Disposition	20	b Place of Dispe			Date	20c. Location -		
9	o o		1 ☐ Burial 2 🛣 Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		-			02-26-08	Odont	on	Maryland_
altimore, Maryland			21. Signature of Funeral Service Lice		V. Arundo	2. Name and Add		02-20-00	ouent	011,	rial y land
B	permi Depa Impo any Ir		Nama 2	() Oliva	De De	onaldson	Funeral	Home & (Cremator	у , Р	.A.
			23a. Part . Enter the disease, or cor	Cultury X				ad Odeni		yLan	Approximate
٥		8 17	23a. Part I. Enter the disease, or cor shock, of heart failure. List only	one cause on each line.	death. Do not en	ter the mode or d	ying, such as care	nac or respiratory a	11031,	1	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final		1000	٨		Nac		1	100
	Examiner		disease or condition resulting in death)	_	URENAL SYNDRIME to, (or as a consequence of): Al culture					<u> </u>	2017
		ē		Due	to (or as a conse	quence of):	P cala	0:5000		i	Es Person
	uted J unsit	튙	•	b	Mon		1 cory	063-01			Jacob
<u>,</u>	certificate be executed iding physician and use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate	Due	to (or as a conse	r as a consequence of):					
68760,	e be sicia e bur										
89	ficat p phy as the	/Medical	resulting in death) Last Due to (or as a consequence of):							į	
Box		₹		d.							
ň	that the death (Iclar	Part II. Othar significant conditions	contributing to dooth but an	t reculting in the I	indorkina asusa i	given in Rest I	23h Did	tohacco use co	ntribute	to the cause of death?
P.O.	the c by the ache	Physi	Fart II. Other significant conditions	contributing to death but not	t resulting in the t	indenying cause !	given in ranti.		Yes 2 No		obably 4 Unknown
	that	by P						_			
g	law requires that the death as been signed by the attel of 2 should be detached for								an autopsy	24b. V	Were autopsy findings vailable prior to
000	w require been si should	ete						pen	ormed?	C	completion of cause of death?
æ	a - E	Completed						10	Yes 2 No		☐Yes 2☐No
Division of Vital Records,	ilclan: The certificate rector, pag		25. Was case referred to medical				OS Diago of i			ive	17E
5		o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA	Wher:	Death <i>(Check only</i> g Home 5 ☐ Res	-	ner (Spec	HOCOILE
ō	Phys r this aral d	5	27. Manner of Death						how injury occur		11 24 65
on	ttanding Phy death. for: After this r the funeral o	ģ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury		/ork? □Yes 2□No				TOU SE
S	il or Attanding after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not	be Ope Place of Injury	At home, farm, st	reet, factory, offic	:e	28f. Location	Street and Numi	oer or Ru	ral Route Number,
2	after Dire	erti	4 Homicide determined building, etc. (Specify)								
_	Hospital 24 hours a Funaral I		29a. Certifier 1 Certifying P	hysician: To the best of my	knowledge, deat	h occurred at the	time, date and pl	ace, and due to the	cause(s) and m	anner as	stated.
	B Hos 24 h P Fur letely	edical		miner: On the basis of examiner and manner stated.							
	To the Hospital or Atta within 24 hours after de To the Funaral Directo completely filled in by th	Me	29b. Signature and title of pertifier	\sim		29c. Lice	ense number		29d. Date signe	d (Monti	n, Day, Year)
	->-0		AAAAA A	OT IN	un	1) 214.	38	Febru	an	23, 2008
į	120		30 Name and address of person when	completed cause of death.	(Item 23a) (Type	Print)		1) · ·	7	C #4
6)		M I HAT	GENTA	W) U4	(1)PF	ENSE F	16 HWA	WHOIN A	PIM	23,2008 SMD4441
1	Sta	ato	31. Date filed (Month, Day, Year)	32. Hegistrar's S	Signature	fack :		. 411. 44	· •		
	Regist		FEB 2 6	2008 Men	S A	September 1					
			\$ NO. 17	4							

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. DHARMASENA

FEB26

31. Date filed (Month, Day, Year)

, MD.

3721

32. Régistrar's Signature

Bress

1:00 PM 2008 4c. County of Death Anne Arundel Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 ☐ Yes 2XXNo 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Delivery 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooklyn Park, Maryland 21225 20c. Location - City or Town, State Stevensville, Maryland 1 2nd Ave SW, Glen Burnie, MD Mo/357 Singleton Funeral & Cremation Services 21061 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Chknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2/23/2008

Registrar DHMH 17 Rev 1/2001

State

POTER Sh.

BALTIMORE, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6 17 PM 21 Irma F. Koenig 2008 FER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES 57. HEALTH CARE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Months Days 1 □ M 2 7 F 03/14/1920 214-12-8386 87 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 □Yes 2 No Director Maryland Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 3929 Foxhill Drive 21043 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married _ 2 🔀 No 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ot Be Francis Marion Riley Mary E. McNamara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any injury or other trau 3929 Foxhill Drive Ellicott City, Maryland 21043 John G. Koenig / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 02/25/2008 | Baltimore, Maryland Loudon Park 21. Signature of Funeral Service Lic 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SOURMOUS CELL 7 HONTHS **Physician** METASTATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of Examine if any, loading to immedi-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an certificate has I 1□ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of D ath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Natural Injury 1 ☐ Yes 2 ☐ No **∠** □ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Records, P.O. Box 68760, or Vital Physician: Hospital or Attending Division

e Hospie...

n 24 hours after death.

he Funeral Director; Af

death

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

29a. Certifier (Check only one) 29b. Signature and title of certifier

Suvæchale

29c. License number

29d. Date signed (Month, Day, Year)

P19923

BALTIMORE

FIEB 91 2508

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOMPELLA, SUVARCHALA 900 S. CATON AVE,

00

31. Date filed (Month, Day, Year)

32. Registrar's Signature



State Registrar

within 2.

ORIGINAL

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nysicia Medic		Registrar 1. Decedent's Name (First, Middle, Last	State of Maryland per verb., g8	' Cei	tificate of De		2. Date of De		752
		Janneke E. Law	,				Month	Day Year 10, 2008 8:3	М
xamine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo		rebrua	4c. County of Death	AH
		3312 Chiswick Co			Silver Sp			Montgomery	
neral ector		5. Social Security Number 6. Se 123-52-5671	x 7. Age (In yrs. Ia ☐ M 2∑ F 70	Yrs.		Hours Min.	8. Date of Bir (Month, Da June 23	ly, Year) Country)	
	}	Usual Residence of Decedent					Julie 25		
Palical Exportat must be notified at	_	10a. State 10b. County		Town or Lo					City Limits s 2 \(\bar{\sqrt{1}} \) No
	ecto	MD Montgome	ry Sil	ver S				10g. Citizen of What Country?	
	급	10e. Street and Number 3312 Chiswick Ct	Bldg 62 #3D		10f. Zip Code	906	1	Netherlands	
	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	i. 13. \	Vas Decedent of Hisp I Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No	14. Race - American Indian	
	Fu	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes	į		Specify:	rican, etc.)	Black, White, etc. Specify: white	
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Ì	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	kind of work done dur OO NOT use retired)	ing most of workin	_g unk	Tob. Kind of Businessamdustry	
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	ToE	Tammp Eldje Dore	nbos			Jantje	Kroon		
1		19a. Informant's Name/Relationship (T)						er, City or Town, State, Zip Code)	
ı	1	William W. Law/sp					2 #3D ate	Silver Spring, M. 20c. Location - City or Town, State	
1		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Terriovar ironi State	metery, cren	sition (Name of natory or other place)		210	200. Location * City of Town, State	
	1	4 风Donation 5 □ Other (Specify, 21. Signature of Funeral Stryice Licens	of ///	22	. Name and Address	ol Facility .		n 1.1	
ļ		Ronald 8	Director		tate Anato altimore.		_	. Baltimore Stre	et
	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due + (r as a c r sequence. Due to (or as a consequence.	ence of):	Yalma	relieve navy	ngg	yuc ;	
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1	ysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome ol pregnar 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time ol de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day	Year
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24 2008 2:05 p February Harrison Lafferty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3016 Black Rock Road Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Director 218-68-6863 NOV 24 1954 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notifiled at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3016 Black Rock Road 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) General Manager Corporate Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilmer Rodgers ۵ T.ee Harrison Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Lafferty - Husband 3016 Black Rock Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc.; 2/25/2008 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee H. Williams ²² Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 0

State Registrar

31. Date filed (Month, Day, Year)

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Name and a

32. Projistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 407 AM Month 2008 TICHARD 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Summit Park Nursing Home Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F 48 Yrs. Maryland 220-74-7806 1959 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1502 Frederick Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Movie Theater 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Lund Roberta Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Lund, Brother 28 Shady Nook Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/26/08 Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Cremation Society Of Maryland, Inc. 299 Fredrick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregory 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreumon14 Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease o, Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s ho 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Baltimore,

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and physician ar s the burial-t attending ed by the a detached f signed to 2 should peen has page certificate After this

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 27110 1∐ Yes

26. Place of Death (Check only one)

2 □ No 1 ☐ Yes

25. Was case referred to medical 1 Tes No. 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 28c. Injury at Work? 1 □ Yes 2 □ No

Other:

28d. Describe how injury occurred

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) February 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main

State Registrar 31. Date filed (Month, Day, Year)

6 Could not be determined

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8:53PM Year **Physician** February 23 2008 MARTHA L LEACH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore BAltimore INAI HOSPITAL of 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | (Month, Day, Year) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F Director 214-38-1438 JULY 21,1941 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ▼Yes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 477 ORCHARD CT. Funeral 21217 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien, Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. 12 HEALTH <u>ASSISTED CARE GIVER</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY LEACH MARY HARGRAVES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY LEACH/SISTER 4029 HILTON ROAD BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 2-26-2008 | BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. BALTIMORE, MARYLAND 21217 1701-31 LAURENS ST. 23a. Partf. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition VASGULAR Acute Cerebral **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** -herosche RoTic HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive HEART 1 Ves 2 No 3 Probably 4 Unknown Completed HyperTension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi DS4558 address of person who completed cause of death (Item 23a) (Type, Print) INAI HOSPITAL OF BURKE JR, MD gistrar's Signature State 2008 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			For State	State of Ma		epartment of I Certificate of			000	0 05756		
100	Di ili		Registrar Decedent's Name (First, Middle, La	ast)		ocranicate or	Death	2. Date of Death		3. Time of Death		
	Physicia /Medic	al		rt W. Lill	iefors			February	23, 2008			
	Examin	er	4a. Facility Name (If not institution, given Montgomery Hospic		se		or Location of Death		4c. County of D			
	Funeral		Social Security Number 6. 9		e (In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)		
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VIOL 12 sho	h and 7 is m traum		19a. Informant's Name/Relationship Liliane M. Lillio			Mailing Address (Street) OB Carteret						
3 - and	f Healt		20a. Method of Disposition	erors/ wire	20h Place of	Disposition (Name of	1	Date 2	0c. Location - City			
Page	ant: if		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Montgo	y, crematory or other pla mery orium, Inc.	rebru 20	uary 28 , 08 Be	ethesda,	Maryland		
permit.	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign kure of Funeral Service Lice	Home/ ^{Bet} Cla, MD 20	hesda-Chevy hase, Inc.							
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	MOO198 If the death. Do no.	ot enter the mode of dy	ing, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
	ysician		Immediate Cause (Final disease or condition resulting in death)	a. Lung	Cancer					Onset and Death		
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Physic	this ce al dire	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		patient 3 DOA				Specify)Hospice		
ding	th. : After s funer	tion:	1 X Natural 5 Pending 2 Accident investigation	(Month, Da		njury Wo	iryat ork?]Yes 2∐No	28d. Describe how	w injury occurred			
r Atter	rector rector by the	Certification:	3 Suicide 6 Could not to determined	Zoe. Place of ing	ury - At home, far c. (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,		
pital o	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 X Certifying P	hysician: To the hest	of my knowledge	, death occurred at the t	ime, date and place	and due to the ca	use(s) and manne	r as stated		
he Ho	in 24 h he Fur pletely	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examination and	d/or investigation, in my	opinion, death occu	rred at the time, da	ite and place, and	due to the cause(s)		
P P	To t	Σ	29b. Signature and title of certifier	10 .1			se number		d. Date signed (M			
	1		30. Name and address of person who	completed cause of d	leath (Item 23a))64615		February	25, 2008		
0+	1		Genevieve Wroble	wski, M.D.	6001 M	uncaster Mi	111 Road,	Rockvill	e, Maryl	and 20855		
	Sta Registr		31. Date filed (Month, Day, Year)	- R	rar's Signature	houte						
	negisti	41	FEB 2 6	2008	47 15	A Property of the Party of the						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 05757 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 19, 2008 **Medical Examiner** 2034 hrs Kenneth Lloyd 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours oreign Director Months Davs Country Wash. 1_X M 2 F 50 Yrs 01-10-1958 Dψ <u>577-80-1589</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Washington DC Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2515<u>22nd</u> 20018 St. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 White, etc. Yes 2 X No 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: Black 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "nat
injury or other transmatic event, the Medical East during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl Laborer Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Willie Moslev 19a. Informant's Name/Relationship (Type, Print) Willie M. Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Temple Hills, MD 20748 Gregory Mosley/Brother Old Branch **4500** 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-26-2008 Burial 2 Cremation 3 Removal from State Suitland, Md Donation 5 Cedar Hill Cemeter Other Specify 22. Name and Address of Facility Ronald Taylor II Funeral HM 108 W. North Ave Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atheroscelrotic cardiovascular disease complicated by influenza Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi Physician/Medical Xunpended AMENDED, 27, perME, g877 3/5/08 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 ٩ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. February 20, 2008 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) FEB 2 6

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

2008

P.O. Division or Vital Records,

filed within 72 hours after death with the Maryland

law requires that the death certificate be executed Physician: Hospital or Attending after death Director: 24 hours a completely within 2

> State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

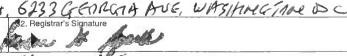
(Check only one)

29b. Signature and title o

Medical

FEB26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Legical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date/signed (Month, Day, Year)

00

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician ed by the atter detached for u or Attending Physicien: tilled in by the tuneral director, Director:

Physician

/Medical

Examiner

Funeral

Director

?7 is marked other then "netural", or items 23a or 28a-f show treumatic event, the Mcdical Examinar must be notified at

and Mentat Hygiene. Is marked other then

permit. Pages 1 and 2 should be a Department of Health and Mental Importent: If Item 27 Is marked o

other

0

injury

Physician

/Medical

filed within 72 hours atter death with the Maryland

Baitimore, Maryland 21215-0036

Manor Care Nursing Home 5. Social Security Number 263-34-8571 Usual Residence of Decedent 10a, State Director 10e. Street and Number 2 New Camp Ct. Completed by Funeral 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 ☐ Divorced 12th grade 17. Father's Name (First, Middle, Last) Be Luther C. Garrett 19a. Informant's Name/Relationship (Type, Print) Johnson Garrett-Nephew 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2 a. Part1 Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immedia e Cause (Final discordition resuling in death) Sequentially list conditions, if any, leading to immediate cause. Enter or Jerging Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 Desidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0059107 02-21-2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REISTERSTOWN MO 21136 210 UMA CENTER DRIVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB26 Registrar 2008

24 hours a

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 25,2008 **Physician** Mc Clelland 4:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 121 Bayside Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 212-46-5706 1 ☐ M 2X F Director 90 February 14,1918 Iowa Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 No Director Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be not 121 Bayside Drive 21222 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any filury or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced To Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years 4 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Horn Effie Distelhorst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell McClelland Son 9011 Millers Island Blvd, Sparrows Point, MD.21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 26, 2008 Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. Signature of Funeral Service Licensee 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failue, but only one cause on each live. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or all a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical SS IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ofie) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner 1 Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. (Month, Day Year) 1 Natural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title 29c. License number

10

State Registrar 30. Name and address

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Evelyn Day Year **Physician** 2008 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7908 ARDMORE AUE BAUTIMORC PARKUILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 212-01-0611 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) AAA Refrigeration + and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager 18 Nother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) lement 193 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is I MO nthia luler-niece 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State nd Mem. Park 2/28/08 BALTI MORE MD 22. Name and Address of Facility ar ford Rd BALTI MORE MD 21234 Evans Funeral Chapel + Cremation Services Parkville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the discrete, ir complifation, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Find **Physician** PCUTE RENAL DAYS FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MI COMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed ohysician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ LENAL RAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CHRUNIC autopsy performed? Yes 2 No OSTEO FORGSIS WITH COMPRESSION 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 1 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director: After the filled in by the funera 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Kley mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, pay Year) 6 2008 32. Redistrar's Signature

2/23/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 25,2008 **Physician** Linda L. McGuire /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson
If Under 1 Year Baltimore 8. Date of Birth (Month, Day, Year) August 22,1950 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Director 215-58-4570 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Ellicott City Howard MD. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21043 4710 Bates Drive USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2X No Specify: White þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Clyde Jones Viola Lorene Burgoon injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau once. 4710 Bates Drive Ellicott City, MD. 21043 Kelly Singer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other prevans Funeral Chapel Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 02/27/2008 Forest Hill, MD. 4 ☐ Donation 5 ☐ Other (Specify) Rel Air 21. Signi ture of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD. 21234 3a. P. rd. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death mmediate Cause (Final disease or condition witting in death) **Physician** Vai /Medical **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 nknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence _ 6 ☐ Other (Specify) this 27. Mannal of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Watural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

Registrar

29b. Signature and title of certifier MPH

29d. Date signed (Manth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Chartes St. Towson 6761

31. Date filed (Month, Day, 26 FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D3y3,2008 **Physician** Ian John Millman 9:14 A. M February /Medical 4a. Facility Name (If not institution, give street and number)
2415 Westridge Road 4b. City, Town, or Location of Death Timonium 4c. County of Death Baltimore County Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Sept. 11, 1938 9. Birthplace (State or Foreign Country) England 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 11 M 2□F **Funeral** 69 215-92-2361 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatith and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Timonium Director Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21093 2415 Westridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Charlotte Hanak James Reginald Millman 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland Mrs. Harlean M. (nee Nelson) Millhan 2415 Westridge Road 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of HIMportant: If ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) refrail tives Funeral Cremation Ctr.,P.A Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. nter the disease, or complications to r Heart failure. List only one cause Immediate Cause (Final 6 MoiThs **Physician** FLIENDCATCINOMO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate 1∐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After Natural 5 ☐ Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TSI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 033409 2(25/08 40

State Registrar

DHMH 17 Rev 1/2001

10053 Falls Raffur Comeralle, Ad, 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SharFim

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Ilia M

31. Date filed (Month, Day, Year)

MO

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene $\angle \cup \cup \Box$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2008 **Physician** Feb. 25. Joseph McKechnie, D.D.S. 3:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSOII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Month, Day,
July 4, 1227 Wine Spring Lane Baltimore 5. Social Security Number Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** MařÿTánd 217-18-4439 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Baltimore Director Md. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1227 Wine Spring Lane 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WWII Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Dentist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph McKechnie Isabella Wilson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla P. McKechnie/Wife 1227 Wine Spring Lane Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/26/08 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 plications that cellised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) **Physician** Tletas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy be detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospitel c within 24 hours at To the Funerel Di 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWIE CHARLES 6701 mp 31. Date filed (Month, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month **Physician** Michael Cooke Maddox February 20, 2008 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4h. Citv. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**X** M 2□ F 608-30-1242 18 04/25/1989 Director Califórnia Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n USA 21286 522 East Seminary Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) Item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 15 - Non Graded Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fire and Mental H Ann H. Maddox permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 Is marked, any injury or other traumatic evone. Jeffrey D. Maddox ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1205 Hollins Lane, Baltimore, MD Jeffrey Maddox/Father 20b. Place of Disposition (Name of Hiff Top creative of other place) Corporation Date 20c. Location - City or Town, State 20a. Method of Disposition 02-26-2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sep 515

Due to (or as a consequence of): 24 hrs **Physician** disease or condition resulting in death) /Medical **Examiner** 24 4-5 Meumonig Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N, Charles St. 54550 Baldine 6535 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician 11.30pM /Medical Town, ος Location of Death of Death Examiner last birthday) (State or Foreign **Funeral** 1 □ M 2 🗙 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Baltenore 10e. Street and Number 10g, Citizen of What Country? items 23a or StoneubrookRd USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 <u>م</u> 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4or 5+) marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other transmetic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ဨ 19b. Mailing Address (Street and Number or Rural Route Number, 3615 Stoney brook 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Luna /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After Certification: 5 Pending investigation 1 Natural **2** ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 054288 30. Name and address of person who completed cause of death (Item 23a) (Type waru

State Registrar 31. Date filed (Month, Day, Year)

FEB26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:36 A M February 20, 2008 Celeste Magnuson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 555 Thayer Avenue #610 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months New Jersev 1 ☐ M 2 🔀 F 218-66-6210 April 4, 1961 Director 46 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 N No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 555 Thayer Avenue #610 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3 Widowed 4 Divorced White the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Magnuson Marie Olivero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Magnuson/Mother 5621 Alta Vista Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Gate of Heaven Cemetery February 26 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee MOO198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio Respiratory Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Chronic Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed Immunodeficiency HIV + sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Pneumonia By Recent History Physician/Medical attending properties of as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the 1 ☐ Yes 2 X No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 X No certificate | Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 Ves 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending Injury 1 X Natural 5 Pending 124 hours after death.

le Funeral Director: A pletely filled in by the fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Silviu Ziscovici, M.D.

FEB 26

2008

30. Name and add

29c. License number

s of person who completed cause of death (Item 23a) (Type, Print) iscovici, M.D. 11400 Rockville Pike #511, Rockville, Maryland 20852

D47167

29d. Date signed (Month, Day, Year)

February 20, 2008

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State of	of Mar	yland /		irtment of H tificate of I		lental Hy	- (200	8	05768
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	/Medic	al	LARRY GEI		1ILLER				4h City Town or	r Location of Death	FEBRU		O 20 County of E		11:00 A M
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	Director	-	209-20-3958 Usual Residence of Decedent								bepe.	3, 1.	750 1.	C11111	37 I Vania
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2	al Hy al Hy roth	Be (17. Father's Name (First, Mid	dle, Last)						18. Mother's Nam	e (First, Mildo	ile, Maiden	Surname)		
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<u>0</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Hygiene is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relat	onship (7	ype. Print)		1	19b. Mailir	ng Address (Street	and Number or Rui	al Route Nun	nber, City oi	r Town, Sta	ite, Zip	Code)
<u>≥</u>	and ealth n 27 ner tr		Josephine K.	Mil	Ler/Wif	e	Look Bloom			Place E.,	Oden Date		MD 2 cation - Cit	111:	
ב	of Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat	on 3 □	Removal fron	n State	20b. Place	etery, crei	sition (Name of matory or other pla		Date	200. Lo	cation - Cit	y OI IU	wii, State
	Pag ment ant: I ury c		4 Donation 5 Othe	r (Specify)		MD N		the state of the s	Pk 2/23	/2008	Laı	urel,	MD	
₫	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Ser	rice Licen	see	100		22	2. Name and Addre	ess of Facility Do	naldso	n Fune	eral :	Home	e, P.A.
0	9 2 E # 9		Janu	UK	100	0	M0110			tt Avenue			D 20	707	A
			23a. Part1. Enter the diseas shock, or heart failure.	e, or comp List only	olications that one cause on	caused t each line	he death. [e.	Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition				diac A							_ 1	Minutes
	/Medical		resulting in death)		Due to	o (or as a	consequen	ce of):							several
	Examiner		Sequentially list conditions		b				ry Diseas	se					years
12	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1	Due to	o (or as a	consequen	ice of):							
	ecute nd trans	ami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c	,								+	
Š	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ŭ	resulting in death, East		Due to	o (or as a	consequen	ice oi).							
0/00	ate b hysic the b	dical			d										
٥	ertific ing p	Mec	IF FEMALE:					-							
X Q Q	ath ce ttendi	an/	23b. Was decedent pregnar in the past 12 months?	t i		birth 2	2 🔲 Fetal de	eath 3	Ectopic pregnanc	у			23d. Date o Month		ery Day Year
5	e deg	sici	1 Yes 2 No		4∐Pre 9☐Unk		time of deat	n 5[Other (specify)_						
Z.	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	Part II. Other significant con	ditions o	antributing to	death hui	t not resultir	ng in the u	ınderlying cause di	ven in Part I.	23e. D	id tobacco u	use contribi	ute to t	he cause of death?
<u>v</u>	res the	by	Part II. Other significant con	iditions o	onanoaning to	douth bu	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.g			1	Yes 2	□ No 3	☐ Prob	pably 4 ∐Unknown
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<u>_</u>	hysic his o	ျ	1 ☐ Yes 2 💢 No] Inpatier	7.1		III 3 DOA	her: 4 Nursing H					fy)
u u	ing P Viter t unera	ü	27. Manner of Death 1 Natural 5 □ Po		(Mo	te of Injury onth, Day		Bb. Time o Injury	Wo		28d. Descri	be now inju	ry occurreo	'	
Division	tendi eath. tor: A	cati	Z L ACCIDENT	vestigation ould not be		of bales	m. At harm	a form of]Yes 2□No	29f Locatio	n /Street ar	nd Number	or Bur	al Route Number,
Ë	or Att	Certification:		etermined	200. Fia	ce of inju- lding, etc	ry - At nome : (Specify)	e, rarm, si	treet, factory, office	,	City or	Town, State	e)	Of Hull	ai noute Wantber,
	urs al		One Continue 457 5	tifuine P	Weights: To 1	he heet -	of my knowle	adne doo	th occurred at the	time, date and place	and due to	the cause/s) and man	ner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 ☑ Cer (Check only 2 ☐ Mer	lical Exa	miner: On the	ne best of anner sta	examinatio	n and/or i	nvestigation, in my	opinion, death occu	urred at the tir	me, date an	d place, an	d due	to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of co	ertifie#	anu mi	17			29c. Licen	se number		29d. Da	ite signed (Month,	, Day, Year)
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1	8		30. Name and address of pe							Cuito 2	רים וח	1400+	+ C:+	5 7	MD 21042
	- 01		Alan Sta 31. Date filed (Month, Day,	hl, M Year)			DOTS€ ar's Signatu		TT DITAE	, Suite 2	OI, EI	TTCOL	L CIL	У	LID CIU4C
	St	ate		-	2008				Associ)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 20° 2008 Sandra Lee Murphy 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Nursing Home Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05/31/1942 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 □ M 2 🗓 F Days Country) 214-40-3211 65 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notifled at 1 ☐ Yes 27 No Director MD Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7978 Nolcrest Road 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2](No Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Kestler Frances Hall 2 other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7978 Nolcrest Road, Mr. Michael Murphy, Jr./ son Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave SW, Glen Burnie, MD MO/357 Singleton Funeral & Cremation Services 21061 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** woni c disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page death? 1 ☐ Yes 2□ No 1∐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA c 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

that the death certificate be executed Division or Vital Records, P.O. Box 68760, peen has certificate

illed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

attending physician and for use as the burial-tran ed by the a signed by d

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State

31. Date filed (Month, Day, Year)

DR OCHANES

FEB26

2008

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

6 Could not be determined

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registra

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-40521

MOSPITAL DRIVE

BURNIE, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

SuiT€

20,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Please Type of Plint in Black indensite ink. Ensure All		000	
			State of Maryland / Department of Health and Me	entai mygii	2008	05770
			1 - State Certificate of Death		g. No.	100110
100	1 × 4		1. Decedent's Name (1781, Middle, 223)	Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ROSE HORTENSE / AC CARRON	FEBRUAR	24 22 200	8 330 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	th 1
		200	SUNRISE ASSISTED LIVING SOVERNAT	ARK	Itane	ARUNDOL
15	Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan. 10, 1	Year) 9. Bir	thplace (State or Foreign buntry)
	Director		319-36-3932 1 Months Days Hours Min.	Jan.10,1	1912	MD
	D		Usual Residence of Decedent			10d. Inside City Limits
	nylan how		10a. State 10b. County 10c. City, Town or Location			1 ☐ Yes 2X No
	Ma-1 s	Ş	MD Anne Arundel Glen Burnie			
	h the	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show The Medical Eyamirar must be notified at	a C	109 Alview Terrace 21060		U.S.A.	
	deat deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9	after or Ite	3	1 Never Married 2 Married 1 Yes 2 No Specify:		Specify: W	hite
င္မ	ours Fig.	by	3 X Widowed 4 □ Divorced Year or Dates:			
9	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)		16b. Kind of Business	/Industry
2	Mec.	ple	Elementary/Secondary (0-12) College (1-4or 5+)			
7	gien gien	no.	8 Homemaker		Own Home	
덛	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	a (First, Middle, M	faiden Sumame)	
<u>a</u>	should be filed nd Mental Hygi marked other umatic event,	To	Thomas Vincent Seymour Sarah El:			
ary	2 sho and h		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
Σ	alth a		Mrs. Mary E. Weidenhoft/Daughter 111 Alview Terrace G			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ones.		20a. Method of Disposition (Name of cemetery, crematory or other place)	28,	20c. Location - City o	r Town, State
2	Page ent o ht: If y or		1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 2008	-	Glen Burn	ie. MD
≣	permit. Pa Departmer Important any injury	l i	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sin	ngleton		
ä	permi Depa Impo any i		Shink MOILING Serivces 1 2nd Aven	nue SW G	len Burnie	. MD 21061
~			23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac of			Approximate Interval Between
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CereBrovascular Accident Due to (or as a consequence of):	VI		3 months
. 74	Examiner		Due to (or as a consequence or).			
		-	Sequentially list conditions, b. Due to (or as a consequence of):			
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rinjury that initiated events			
_	be executed ician and burial-transit	хаг	that initiated events resulting in death) Last			
760,	eath certificate be executed attending physician and for use as the burial-transit	calE				
687	phys the					
×	ding	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
Вох	ath c	lan	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mooths? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
o.	at the de by the a	ysic	1 Yes 2 No 9 Unknown			
4	that the			23e. Did tot	pacco use contribute	to the cause of death?
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of Vital Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Completed	027.00	24a. Was a	a Jah Wara	autopsy findings available
ec	alaw hast e 2 s	du	CHRONIC OBSTRUCTIVE PULMONARYDISA	autops perform	y prior to	completion of cause of
<u>=</u>		Ö			2 No 1 Y	
/ita	Physician: Th r this certificate ral director, pag	Be	avaminar?	th (Check only on	10)	ASSISTOD
\leq	hys his di	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		ence 6 other (Sp	Decily LIVING
	ding P h. After 1 funera	£	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28b. Time of Injury 28b. Time of Injury 28b. Time of 28c. Injury at Work?	280. Describe in	ow injury occurred	
Sio	eath or: A	cati	2 Accident investigation 3 Suicide 6 Could not be	004 1 100	treet and Number or	Dural Pauta Alumbas
Division	ter d	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town		nurar noute reamber,
0	ital c					
)	tosp 4 hou Fune ely fi	Medical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur.	read at the time d	late and place, and d	ue to the cause(s)
	the l	Aed	one) and manner stated.		9d Date signed (Mo	nth. Dav. Year)
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral complet	-	29b. Signature and title if certifie MO 29c. License number	1	- Desiles	77 7008
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1	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	M	i DOSAL .	aMD ZIIna
_	†		IV/ICHAEL/+, MNICRIM NO DEUL VOTERANS HIGHIN	W/1./11	LERSVILL	E112 -1108
		ate	CED VE VIIIX PRIMARY AND THE	•		
407	Regist	rar	LEDRO			

Ivial tilla ivielsel		I- For State Registrar	Certificate	of Death		g. No. 2008-	05771			
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) MARTINA LYNN MERSON	· · · · · · · · · · · · · · · · · · ·		2. Date of Death Month Day Year February 11, 2008 3. Time of Death 1547 hrs					
Wedical Examin	iei	4a. Facility Name (if not institution, give street and nun	nber)	4b. City, Town, or Location o		4c. County of Deat				
		1865 Grempler Way		Edgewood		Harford				
Funeral Director		-	7. Age (In yrs. last birthday	Months Days Hours	Min.	h (MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn New Jersey buntry)			
	-	243-37-8948 1 M 2 _X F Usual Residence of Decedent	40	Yrs.	Jan. 2	26, 1968 ⁶				
w any		10a. State 10b. County	10c. City, Town or L		10d. Inside City Limits 1 Yes 2 🔀 No					
yland •-f sho	į	Maryland Harford 10e. Street and Number	Edgewood	10f. Zip Code	I_10	g. Citizen of What Cou				
he Mar or 283	Director			21040		USA				
leath with the Mar ritems 23a or 28.				. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,			rican Indian, Black,			
r death	Funeral	1 Never Married 2 Married Armed Fo	2 X No		rueno Rican, etc.)					
urs afte tural", uminer	ā	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grad-	e completed) 16a. Dec	Yes 2 No specify: edent's Usual Occupation (Give leading)		Specify: What 16b. Kind of Business	nite			
5 72 hou cal Exe	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+) durin	ng most of working life. DO NOT	use retired)					
003(within giene. ner the	gwo	12 17. Father's Name (First, Middle, Last)	Bus	iness Manager	's Name (First, Middle, M	Retail				
215- e filed tal Hyg ked oth	Be C	Willis B. Davis			ja (nmn) Dr	,				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Num			e, Zip Code)			
and 2 s ealth ar em 27		Stephanie Merson / Daug 20a. Method of Disposition		65 Grempler Way	, Edgewood, Date	, MD 21040 20c. Location - City of	or Town, State			
TOFE ages 1: nt of H t: If it		1 Burial 2 Cremation 3 Removal fro	III State	or other place) Service Corp	2/21/2008	Towson, N	Mary land			
altin mit. P. partme portan ury or	1	4 Donation Other Specify: 21. Schature of Prior ervide/Licens		22 Name and Address of Facility MCCOMAS Funera			arytana			
		23a. Part I. Enter the disease, or complications that ca		1317 Cokesbury	Road, Abir	nadon, MD 2	21009 Approximate Interval			
Physician /Medical		failure. List only one cause on each line.		nter the mode of dying, such as ca	ardiac or respiratory arre	est, shock, or near	Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac A Due to (or as a	consequence of):	······································						
	7.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):		<u> </u>					
	Examiner	cause. Enter Underlying Cause								
recuted and ransit		d	consequence of):							
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760, ficate be g physici s the buri	√Me	IF FEMALE: 23c. If yes, of the little bit is a constant of the	utcome of pregnancy		pregnancy	23d. Date of delive Month	ery Day Year			
Box 687 death certifice the attending p	sician/I	past 12 months?	ant at time of death 5	Other (Specify)						
9 + 5	Phys	1 Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to		the underlying cause given in Pa	art I. 23e. Did to	bbacco use contribute t	to the cause of death?			
of Vital Records, P.O. in Physician: The law requires that the Wher this certificate has been signed by the meral director, page 2 should be detached.	ð	Tartin Still Organization Still Stil	dodan bar not roodining in	and analonying decear great in the		s 2 No 3 Pr	obably 4 Unknown			
cords, law requir has been s	Completed				24a. Was autop		autopsy findings available o completion of cause of			
Ceco	omp		 			rmed? death?				
Vital Rec visitian: The his certificate director, page	Be C	25. Was case referred to medical examiner?		26.Place of Death						
of Vit	ď	1 ✓ Yes 2 No	ppatient 2 ER/Outpa	e of Injury 28c. Injury at Work		Residence 6 Oth	ner: Scene			
ion of lending Pheath.	Certification:	1 X Natural 5 Pending (Month,	Day,Year)	1 Yes 2	No					
Division tal or Attendii rs after death. al Director: A	ifica	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At home, farm,	street, factory, office building, et	tc. 28f. Location (S		Rural Route Number, City			
Divi	Cert	4 Homicide determined (Specify) 29a. Certifier A O Attain Physician Tathabas				· · · · · · · · · · · · · · · · · · ·				
To the Hos within 24 h To the Fur	Medical	one) Certifying Physician: To the bes	f examination and/or inve	occurred at the time, date and pla stigation, in my opinion, death oc	ace, and due to the caus ccurred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)			
To To COI	Me	and manner st	ated.	29c. License number		29d. Date signed (A	fonth, Day, Year)			
		J. M. 1		O.C.M.E.		February 12, 2	008			
		30. Name and address of person who completed caus Jack Titus MD. Deputy Chief Medic		Penn Street, Baltimore,	MD 21201					
St	ate		gistrar's Signature	. Sim Gardon Baramoro,						
Regist		FEB 2 6 2008	du A	()						
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		For State C		artment of Health and I rtificate of Death		g. No. 2 1 1 8	05772				
Physicia /Medic		Decedent's Name (First, Middle, Last) CLARA		MAHR	2. Date of Death Month FEBRUARY		3. Time of Death 6:20 P M				
Examin	er	4a. Facility Name (If not institution, give street and nu JEWISH CONVALESCENT & 5. Social Security Number 6. Sex	·	4b. City, Town, or Location of Death BALTIMORE If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death BALTIMORE 9. Birthp	ace (State or Foreign				
Director		215-74-1535 1□M 2X F Usual Residence of Decedent	100 Yrs.	Months Days Hours Min.	0473071	907 Couin	MD				
faryland show ed at	or	10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo			1	0d. Inside City Limits 1				
th the N or 28a-1 e notifii	Director	10e. Street and Number	BALT	10f. Zip Code	10:	g. Citizen of What Coun	try?				
leath wi	Funeral I	7920 SCOTTS LEVEL ROAD 11. Marital Status 12. Was Dec	edent Ever in U.S. 13. \	t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W							
ours after death with the Marylar rai", or Items 23a or 28a-f show Examiner must be notified at	þ	1 Marriad Status 1 Never Married 2 Married 1 Yes 3 Wildowed 4 Divorced Armed F 1 Yes 1 Yes Year or D	2 MiNo ive	f Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 X No <i>Specify:</i>		Black, White,	WHITE				
be filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give life. [dent's Usual Occupation kind of work done during most of wor OO NOT use retired) HOMEMAKER	king 1	6b. Kind of Business/Ind	lustry				
0 - 0 -	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, M	aiden Surname)	TNADLE				
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone.	2	UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print)	MANDELL 19b. Mailir	UNOBTA ng Address (Street and Number or Ru			Code)				
1 and 2 Health a em 27 is ther tra	g a	MICHAEL MAHR / SON 20a. Method of Disposition	20b. Place of Dispo	MONA NORTH, #6, B		MD 21208 Oc. Location - City or To	wn, State				
Pages nent of ant: If its		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	natory or other place) EMORIAL PARK 02/2		•					
permit. Depart Imports any inj		21. Signature of Funeral Service Licensee		2. Name and Address of Facility S R900 REISTERSTOWN		ON & BROS.	INC. MD 21208				
Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final	caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death				
/Medical Examiner		disease or condition resulting in death)	(or as a consequence of):	· Cardinasa	Di	10110	Ver				
p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	(or as a consequence of):	<u> Clarativa</u>	W 17(1	Cac) C	frus				
eath certificate be executed attending physician and for use as the burial-transit	I Examiner	triat iritiated events	(or as a consequence of):								
ificate b g physic as the bi	edica	d									
The law requires that the death certificate be the has been signed by the attending physicial oage 2 should be detached for use as the bur	Physician/Medica	in the past 12 months?	nant at time of death 5	⊒Ectopic pregnancy] Other <i>(specify)</i>		23d. Date of delive Month	ary Day Year				
w requires that been signed by should be deta	þ	Part II. Ather significant conditions contributing to a	leath but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to ths 2 No 3 □ Prob					
: The law recate has be page 2 sho	Completed				24a. Was an autopsy perform 1∐ Yes 2	prior to co	psy findings available mpletion of cause of				
Physician: The la rr this certificate ha	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Hospital:} \) 1 \(\text{I} \)	Inpatient 2 ER/Outpatien	Other: \	ath <i>(Check only one</i> Iome 5 ☐ Resider	nce 6 □Other (Specif	· · · · · · · · · · · · · · · · · · ·				
E Harring	ion: T	Takatulai 3 I eliulig	of Injury ofh, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	w injury occurred					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Plac	e of injury - At home, farm, str ling, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,				
e Hospit 24 hour e Funera etely fille	Medical ((Check only Medical Examiner: On the	e best of my knowledge, deatl basis of examination and/or in oner stated.	h occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as sate and place, and due to	tated. the cause(s)				
To the within 2 To the complex	Me	29b. Signature and little of certifier		29c. License number		od. Date signed (Month, $\frac{23}{24}$					
2 1		30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Y34 W Zol	veder	2/23/20	•				
Sta Registr			Registrar's Signature	Carll &		, - 10					
DHMH 17 Rev 1/20		FEB 2 6 2008									

		1 - For State Registrar	State of IVI	aryiand /		tificate of t			,	giene Reg. No	0001	2 0	2770	
Physici	an	Decedent's Name (First, Middle	, Last)						Date of De Month	ath Da	y Year		ne of Death	
/Medic		Hung Nguyen							Februar		3, 2008		45 A. ^M	
Examin	ier '	4a. Facility Name (If not institution	,			4b. City, Town, or		of Death		4c. County of Death				
<i>₽</i>		23 Glenwood Ave				Catonsv		-0411			Baltin			
Funeral	ō	5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours	r 24 Hrs. Min.	Date of Bir (Month, Da	th ay, Year,	9. B	irthplace <i>(St</i> Co <i>untry)</i>	ate or Foreign	
Director		479-23-0897	1351111 221	68	115.		<u> </u>		Oct. 10	6, 1	939 Vie			
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation						10d Insid	le City Limits	
anyla sho sd at	5	Maryland Baltin	m 0.14			ville							Yes 21 No	
he M 8a-f otifie	Director		nore	Cat	JUHS									
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ath v	a	208 Slitting M:				2122				US				
r de:	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic O an, Mexic	rigin? (Spe	cify Yes or No Rican, etc.))-	 Race - An Black, Wh 		n,	
or it		1 ☐ Never Married 2 🔀 Marri	If Yes, Give	No		☐Yes 2☐XNo			,		Specify:Vie		se	
nours ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:											
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vithin ne. han	E	Elementary/Secondary (0-12)	Coilege (1-4or	5+)		O NOT use retired	"			77.		A		
led v lygie her t		47 F-0-3-N	1 4			Major	40. 11-11		(F) M		tnamese	Army		
be find hital hital hital he ever	Be	17. Father's Name (First, Middle,							(First, Middle,	, Maider	i Surname)			
ould Mer arke	은	Thieu Nguy												
2 sh and is m		19a. Informant's Name/Relationsh			b. Mailin	g Address (Street a	and Numi	ber or Rura	I Route Numb	er, City	or Town, State	, Zip Code)		
and lealth m 27 her t		Phuong Hoang La	m Wife			litting								
Jes 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State			sition (Name of natory or other plac		_	ate		ocation - City o			
men ant:		4 ☐ Donation 5 ☐ Other (Sp		St. Jo		Cemeter	- ;	2/26/	- 1		icott (•		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	iscensee //		22	Name and Addressineral Ho 30 Edmon	s of Faci	Ster f	ling As	shto	n Schwa	ab Wit	zke	
20 E # 9		Coffe Kel	1 Tlum	gn.	16	30 Edmon	dson	Aven	ue: Cai	tons	ville,	MD 21	228	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	d the death. Do	not ente	er the mode of dyin	g, such a	s cardiac o	r respiratory a	rrest,		Approx		
Physician		Immediate Cause (Final disease or condition	H20	atace	RA	inoma		Mel	tasta	ti		Onset	month month	
/Medical		resulting in death)	a. Due to (as	a consequence		1110110)	-	/ 1 / 1 0	7,000	سے		<u> </u>	7763 77 40	
Examiner														
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cate be executed physician and the burial-transit	Examiner	l that initiated events	c.											
an ar rial-t	EX	resulting in death) Last	Due to (or as	a consequence	e of):									
tte be iysici	edical		d											
# D &		IC CENAL C	1				20112			-				
eath cerratending	Nu.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 □ Fetal deat	th a□	Ectopic pregnancy					23d. Date of d	elivery		
dear le att	Physician/N	in the past 12 months? 1 ☐ Yes 2 █ No	4☐Pregnant a			Other (specify)					Month	Day	Year	
at the de by the stached	h Š	9 Unknown	9∐Unknown											
w requires that been signed to should be deta	by F	Part II. Other significant condition	ns contributing to death b	out not resulting	in the un	derlying cause give	en in Part	l.	23e. Did t	obacco	use contribute	to the cause	of death?	
en siç	pa								1 🗆 '	Yes 2	No 3□	Probably 4	4 ∐Unknown	
s bee	Completed								24a. Was		24b. Were	autopsy find	ings available	
The It	E O									rmed?	death'	completion		
		25. Was case referred to medical					26 Plan	o of Death	1∐ Yes (Check only o	2) No	1 1146	es 2 No		
/sician; s certific firector,	o Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/O	utnatient	3 DOA Othe	ar.	lursing Hor	- 4		6 ☐Other (Sp	noif il		
i or Attending Physician: after death. Director: After this certifica d in by the funeral director, I		27. Manner of Death	28a. Date of Inju	ıry 28b.	. Time of	28c. Injury	/ at		28d. Describe			еспу)		
th. : After e funer	ţi	1 Natural 5 ☐ Pending 2 Accident investig	g (<i>Month, Da</i> jation	y Year)	Injury	M 1 1	<br Yes 2[]No						
Atter dea ector	fica	3 Suicide 6 Could n	and Zoe. Flace of fill	ury - At home, f	farm, stre	et, factory, office		2	28f. Location (Street a	nd Number or i	Rural Route	Number,	
after after din t	Certification	4 ☐ Homicide determi	building, et	tc. (Specify)					City or Tol	wn, Stat	e)			
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledg	ge, death	occurred at the tin	ne, date a	and place, a	and due to the	cause(s	and manner	as stated.		
e Ho 1 24 h e Fu letel	Medical	(Check only 2 ☐ Medical ! one)	Examiner: On the basis of and manner st	of examination a	and/or inv	estigation, in my o	pinion, de	eath occurr	ed at the time,	date an	d place, and d	ue to the cau	use(s)	
Nithir Somp	Me	29b. Signature and title of certifier				29c. License	number			29d. Da	ate signed (Mo.	nth, Day, Ye	ar)	
		> auli	Tongh	4		D26	25	6		2	125/	08		
9		30. Name and address of person of BIC + Du 0 N 31. Date filed (Month, Day, Year)	who completed cause of d	leath (Item 23a)) (Type, F	Print) -		,		1. 1	1	140	77177	
		BICH DUON	15, MD 7	24 M	air	len ch	500	e la	ne l	sal	umn	e Mil	414	
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature										
Registr		FEB 2 6 2	008	ar's Signature	A 154									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Emmert 5:40A M Lincoln 011er February 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director 213-03-7595 92 20, 1915 PA Nov. Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 ☐Yes 2XINo Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 384 Fleagle Road 21061 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If feen 27 Is merked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Chemical Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmert 011er ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Oller/Son 302 King George Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Chesapeake Creamtion 4 Donation 5 Dother (Specify) Stevensville, MD 22. Name and Address of Facility
Singleton Funeral & Creamtion Svs 21. Signature of Funeral Service Licensee 2nd Ave., S.W. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 signed by the attending physician d be detached for use as the buria Physician/Medical IF FFMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has I autopsy performed this certificate 2/10 Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 □ No 2 DFN/Outpatient 3□ DOA ၉ 1 🔲 Inpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director:. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, cal 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

ess of person who completed cause of de

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th (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Poace /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Kandal enesis (ount 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreig Country) **Funeral** Months Days 1 □ M 2 🗙 F 220-22-5292 Director 93 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y☐Yes 2☐No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. Conway Street apt 502 Funeral West 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: þ Specify. 3X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Hospital 10th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola Myrtle William Peace 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 3530 Resource Drive, Randallstown, Md Eugene Richardson-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/28/08 Md 4 Donation 5 Other (Specify) Randallstown, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1□ Yes 2 10 H 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2/21NO Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check ont 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **29**b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

MPH 9109 liberty Road,

Randallstown, MD 21/33

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division or Vital Records, P.O. Box 68760, in 24 hours after the Funeral Director. After malately filled in by the funeral properties of th within 24 hor To the Fune completely fi

> State Registrar

29a. Certifier

29b. Signature and title of certifier



ATTENDING CARDIOLOGIST

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MARYLAND

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State State Registrar	•	artment of Health and N rtificate of Death	nental Hygien Reg. N	0 0 0 0	05777
- 10			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
4.	Physici /Medic	al	Il Park			feb 11	6 2008	08:00 PM
)	Examin		4a. Facility Name (If not institution, give street an ST. AGNES HOSP	ITAL	Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 17 M 2	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct 12, 19	9. Birthp Cour 944 Kore	lace (State or Foreign htry)
	land ow ut		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	a-f sh	ctor	MD Baltimore	Caton	sville			1 ☐ Yes 2 No
	n with the 3a or 28 st be not	al Director	10e. Street and Number 815 Winters Lane		10f. Zip Code 21228	10g. (Citizen of What Cour	itry?
336	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Kerda Hygiene. marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show marked other than "natic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2.17MNo	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerform 1 ☐ Yes 2 【 No Specify:	ecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: asi	etc.
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CA	be filed w Ital Hygie d other tl event, th	Be	12 4 17. Father's Name (First, Middle, Last)		unk 18. Mother's Nan	ne (First, Middle, Maid		unk
Maryland	d 2 th all	2	19a. Informant's Name/Relationship (Type. Print Kyu Lee/friend		ng Address (Street and Number or Ru Winters Lane Cator			Code)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 i iry or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 ☑ Other (Specify) in	from State	osition (Name of matory or other place)	Date 20c.	. Location - City or To	own, State
Balti	permit. Page Department of Important: If any Injury or once,		21. Signature of Juneral Service Linnsee Wade	2 Name and Address of Facility Late Anatomy Board altimore, MD 2120		altimore S	treet	
	Physician		23a. Part1 Enter the disease or complications shock or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Di	ue to (or as a consequence of):		J		
	routed and transit	Examiner	Sequentially list conditions, if the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events could be in ideath) Last					
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Di	ue to (or as a consequence of):				
Box 6	requires that the death certifics neen signed by the attending ph hould be detached for use as the	sician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	very Day Year
rds, P.O	Se La	d by Phys	Part II. Other significant conditions contribution	g to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
Division or Vital Records,	s t	Completed				24a. Was an autopsy performed	prior to o	opsy findings available ompletion of cause of 2 No
/ita	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner?		Othor:	ath Check onl one		
on or	ing Physi After this c uneral dir	ion: To	27. Manner of Death 1 Natural 5 Pending	1 ☑npatient 2 ☐ ER/Outpatie Date of Injury (Month, Day Year) 28b. Time Injury	THE SELECT 4 NUTSING P	forme 5 ☐ Residence 28d. Describe how i		ify)
Divisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	e Hospital 24 hours a e Funeral I letely filled	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, dea the basis of examination and/or d manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	MD	29c. License number . P 2 0 6 5 7		Date signed (Month	_
•			30. Name and address of person who complete Mahmoud AL-Dano	lashi, 900 Cata	on Ave, Baltimo	re, MD 2	21229	
	St Regist	ate trar	31. Date filed (Month, Day, Year) FFB 2 6 2008	32. Registrar's Signature	Lock			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb. 2008 **Physician** М 1PM Polhemus Coletta A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Marley Neck Health Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 30 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□M 2 🗡 F 1917 Bellevue Iowa 91 484-14-2624 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Severna Park Director Anne Arundel 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA 526 Heavitree Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 Specify Specify 2 3 ☐ Widowed 4 ☐ Xoivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hairdresser 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Herria Marv Ellen Horan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 526 Heavitree Lane Severna Park MD 21146 Mary Ellen Regan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 02/26708 1 Deurial 2 □ Cremation 3 □ Removal from State St. Peter & Paul Catholic Cem Springbrook Iowa 4 □ Donation 5 □ Other (Specify) 21. Signal re of Funeral Service Doensee Stallings Funeral Home P.A. 22. Name and Address of Facility 3111 Mountain Road Pasadena MD 21122 23a. Part1. Enter the disease, or comilica ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 2 deal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as the l IF FEMALE for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9□Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate has 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2□10 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🗌 Inpatient Certification: To this 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28a, Date of Injury 28c. Injury at Work? After (Month, Day Year) the Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident d in by the f 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide the Funeral D mpletely filled ir hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier ್ತಿ 2 231 Annapolis n Day, Year) FEB 2 6

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State Registrar

Division or Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completely filled in by the funer.

114142		TO 2 INO S TIODADIY 422 OTIKIOWIT		
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No		
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5□ Residence 6 🗗 🕳 RepeSy) House		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n (Month, Day Year) injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined		 Location (Street and Number or Rural Route Number, City or Town, State) 		
29a. Certifier (Check only one) 1 Certifying Pl 2 Madical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination end/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)		

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

cal

29b. Signature and title of certifier

30. Name and address of pe

Ullesm

n who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Mary	land		artment of H		Mental Hy	/giene	008	05780
Physici	an	1. Decedent's Name (First, Middle,	Last)		-			2. Date of D Month	Day	Year	3. Time of Death
/Medi		Wilmer A.				th Oits Tavas as	. Ition of Dooth	February		2008 County of Dea	2:22 P M
Examir	ner	4a. Facility Name (If not institution, 324 Broadwood	-			Rockv	Location of Death			Montgo:	
Funoral				yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B			thplace (State or Foreign
Funeral Director		578-42-3271	¹⊠M 2□F 76		Yrs.	Months Days	Hours Min.	Jan. 10		2 Wash	ington, D.C.
pu ,		Usual Residence of Decedent 10a. State 10b. County	10	c City	, Town or Lo	cation					10d. Inside City Limits
faryla shov	5	,									1 X Yes 2 □ No
the N 28a-1 notifi	rect	Maryland Montgo 10e. Street and Number	mery		Rockv:	10f. Zip Code			10g. Citiz	en of What Co	ountry?
n with	Funeral Director	324 Broadwoo	d Drive			2085	1		Uni	ted St	ates
death	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S	3. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	10-	4. Race - Ame Black, Whi	
s after ; or it	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 No If Yes, Give Year or Dates:			1 □ Yes 2 🖾 No	Specify:			Specify: T.T	hite
hours at tural, or	q pa	15. Decedent		-	16a. Dece	dent's Usual Occup	ation		16b. Kir	w) nd of Business	
in 72 n "na Medic	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)	\dashv	(Give life.	kind of work done DO NOT use retired	during most of wor d)	king	Res	tauran	t and
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yia ould to Meni marke natic c	ျ	Arthur W. Que			40h Maille	ng Address (Street		ine A.			Zin Cada)
INIAI nd 2 sh lith and 127 Is m		19a. Informant's Name/Relationsh				Broadwood					
Healt Healt tem 2	16	20a. Method of Disposition	ell/ Wile 2	20b. P	lace of Dispo	sition (Name of matory or other place	>	Date		cation - City o	
Pages ent of nt: If I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	3 Intellioval Holli State		_	s Cemetery	i CDIG	ary 27, 08	Rock	ville.	Maryland
DEMILITIOTE, IMETYIGITE ZIZIONOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service			2	2. Name and Addre	ss of Facility				-
		KAT	M00							ville,	11e Inc MD 20850-2805
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final				ter the mode of dyir		c or respiratory	arrest,		Approximate Interval Between Onset and Death 1 Year
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certificate ding physise as the	8	TE EEMALE.			-						
death cer e attendir	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p	∃Feta	Ideath 3	⊒Ectopic pregnanc	у		2	23d. Date of do Month	elivery Day Year
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that the ed by detac		Part II. Other significant condition	ons contributing to death but n	ot resu	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Di	d tobacco u	se contribute	to the cause of death?
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HECOTOS he law requires has been sign tge 2 should be	Completed							24a. W	as an Itopsy	24b. Were a	autopsy findings available completion of cause of
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r VITAI KEO ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?				Ott	26. Place of De				
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	tion	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, Day Ye	ear)	Injury	Wo	rk?]Yes 2∐No			,	
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To the within 2	Me	29b. Signature and title of certifie				29c. Licens				-	nth, Day, Year)
	-	1 faul	Mamlo			Pol	61083	>	TE	325,	2008
177		30. Name and address of person									
12		Paul M. Thambi					ve Suite	300 Ro	ckvi1	le, Ma	ryland 20850
Si Regis	tate trar	TER 2. 6		1	K AS	ente					

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George Cornelius	1	dmond - For State				nd / De	epart	ment of ficate of	Heal	th and			-	eg. No.	2	nn	8 057	9
Physicia Medical Examin	n/	Registrar 1. Decedent's Name GEORGE			REDM	OND					-	2	2. Date of Dea Month February	ıth	Year	3	Time of Death 0328 hrs	
		4a. Facility Name (if Harbor Hosp			et and num	ber)		4	ь. City, Baltir	Town, or Lo	cation of I	Death		4c.	County of	Death		
Funeral Director		5. Social Security No. 212–76–53		6. Sex		. Age (In y	yrs. last	birthday) Yrs.	Month	ler 1 Year ns Days	If Under :	24Hrs. Min.	8. Date of Bi	•	- 11	9. Birth Foreign Cour	place (State or IRGINIA	
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s after deat rral", or ite	by Fun	Never Marrie Widowed 15. Decedent's Edi	4 Div	orced If Yes	Yes s, Give Year ates:	2 X N		1		No Counatio		nd of w	ork done		Specify:	BLAC		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Second 12TH			College (1-		-	during m	ost of wo	orking life. D	OO NOT u	se retire	ed)	4			CORPORATIO	N
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Division pital or Attendit ours after death teral Director: A	Certification:	3 Suicide 4 Homicide	6 Cou	ld not be rmined		of Injury		me, farm, stre t	eet, facto	ry, office bu	uilding, etc	- 1	28f. Location or Town 2500 South	. State)			ral Route Number, C ore, MD	ty
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	Ž	29b. Signature and	title of certifi	er	3	Kup	>		2	9c. License O.C.N					Date signo oruary 2	,	nth, Day, Year)	
6		30. Name and addr Tasha Gree			leted caus				Penn	Street, I	Baltimo	re, M	21201					
St Regist	tate trar	31. Date filed (Mon	6 200	3	32. Re	gistrar's S	Signatu	book										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0351 A M Michael H. Robinson 25 February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE SAINT AGNES HEALTHCATE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 13, 1925 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Mary Land 1X M 2 □ F Months Min. 219-10-5623 Oct Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Item 27 Is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 No Director Howard Elkridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5770 Railroad Avenue 21075 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: 1943 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Warehouse 4 Laborer permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marken any Injury or any Injur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Robinson, Wife 5770 Railroad Avenue Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/25/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensee Thomas Gregor R. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician arythmia Cardiac 1 minute /Medical Due to (or as a consequence of) **Examiner** myorardial 20 minuts Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Michael H. Kov Division or Vital Records, 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 2 ER/Outpatient P 1 Inpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? I or Attending Paffer death. Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lebruary 25, 2008 MD B19916795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) meghan Avenue Checkley 900 South

State

Registrar

31. Date filed (Month, Day, Year)

32. gistrar's Signature

gnature Appendix

ORIGINAL

			For State Registrar		State of Ma	aryland		tment of I		d Mental Hy	/giene Reg. No. 2	008-	05783
	Physici /Medi	cal	Ma	ne (First, Middle, Las	KY	BI	CKI	b. City, Town,	or Logation of F	2. Date of D	S ZI Z	year of Death	3. Time of Death
	Examir	ier		(If not institution, give Hospital	e street and number)			Baltimore		Jeath	N/A	ity of Death	
			5. Social Security I		ex 7. Age	e (In vrs. la		If Under 1 Year		Hrs. 8. Date of B		9. Birtholad	ce (State or Foreign
	Funeral Director		218-22-2	2790 1		30	Yrs.	Months Days	Hours I	Hrs. 8. Date of B (Month, D Feb. 1	, 1928	Md.	,)
	land ow It		10a. State	10b. County		10c. City,	Town or Loca	tion				100	I. Inside City Limits
	e Mary 8a-f sho tified a	ctor	Md.	N/A		В	altimore						1XYes 2□No
	with the	Funeral Director	10e. Street and Nu 29 N. 3	^{umber} Streeper St.				10f. Zip Code	21224		10g. Citizen o	f What Country	/?
	death ms 2: r mus	nera	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S	. 13. Wa	s Decedent of l	Hispanic Origin	? (Specify Yes or Note:)	lo- 14. R	ace - American	
920	72 hours after death with the Maryland natural", or Items 23a or 28a-f show disal Examiner must be notified at	2	1 □ Never Mar 3 ⋉ Widowed	rried 2 Married 4 Divorced	1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:	No		Yes 21 No		uerto riicari, etc.)		city: White	
5-0	72 ho natur tical	eted	(Spe	15. Decedent's Ed	lucation de completed)		16a. Deceder	nt's Usual Occu and of work done NOT use retire	pation during most of	f working	16b. Kind of	Business/Indu	stry
21215-0036	within ene. than "	Completed	Elementary/Sec 3 yrs.	ondary (0-12)	College (1-4or 5	i+)		shoremen	nd) -		Port	of Balto	•
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be Co		e (First, Middle, Last) ybicki					1	Name (First, Middle Lia Urbano		ame)	
ary	2 shou and M is mar aumat	-	19a. Informant's N	Name/Relationship (Type. Print)		19b. Mailing	Address (Stree	t and Number o	or Rural Route Num	ber, City or Tow	n, State, Zip C	code)
Σ,	and 2 ealth m 27 i			J. Rybicki J	r. son	T-01 -1				imore Md. 2	,		
Baltimore,	permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trat		20a. Method of Disposition 1									n - City or Town	n, State
Balt	permit. Departi Importi any Inj		21. Signature of										
	Physician /Medical Examiner		23a. var 1. Enter sh ck, or he Immediate Cause disease or conditi- resulting in death)	(Final on	ole cause on each lir a. Due to (or as	13 5	MANDA	the mode of dy	ing, such as ca	rdiac or respiratory	arrest,	3	Approximate Interval Between Onset and Death
1/		Examiner	Sequentially list of any, leading to it Cause (Disease of that initiated event	ts 🔳	b	a conseque	ence of):						
8760,c	cate be executed oblysician and the burial-transit	dical Ex	resulting in death)	Last	Due to (or as	a conseque	ence of):						
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ds, P.O	w requires that the d been signed by the should be detached	b	Part II. Other sign	sificant conditions	ontributing to death b	ut not resul	ting in the und	erlying cause gi	ven in Part I.		tobacco use co		cause of death?
I Records,	has has	Completed								24a. Wa auf per 1 Yes	topsy formed?	prior to comp death?	sy findings available pletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case refe examiner?	erred to medical						f Death (Check onl)	one)		
or V	.si <u>y</u> s	은	1 ☐ Yes 2	≱ 4⁄0	Hospital: 1 Inpatie		R/Outpatient	OL BOIL		ing Home 5□Re	sidence 6 🗆 0	Other (Specify)	
iono	ffer nel		27. Manner of Dea 1 Natural 2 ☐ Accident	ath 5 □ Pending investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inju Wo M 1	uryat ork?]Yes 2∐No		e how injury occ	curred	
Division	al or Atte s after des il Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injuding, et	ury - At hor c. (Specify)	me, farm, stree)	t, factory, office			(Street and Nu own, State)	mber or Rural i	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	Certifying Ph 2☐ Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examinati	vledge, death o on and/or inve	occurred at the stigation, in my	time, date and opinion, death	place, and due to the occurred at the time	ne cause(s) and e, date and plac	manner as sta e, and due to t	ted. the cause(s)
	To the within 2 To the comple	Me	29b. Signature an	d title of certifier	7 =#				se number	34	29d. Date sig	ned (Month, D	ay, Year)

29b. Signature and title of certifier

42634

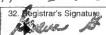
29d. Date signed (Month, Day, Year)

OSEPH

30. Name, and address of berson who completed cause of death (Item 23a) (Type, Print)

SOSEPH COSTA 33 (ST PAU PLACE BACTIVI DE MY 21202

State Registrar



) *	Physic /Medi Examii	cal
	uneral irector	
the Maryland	· 28a-f show notified at	roctor

	Physici	an	Decedent's Name (First, Middle, Last)					Date of Deat Month	h ZUUU Day Year	3. Time of Death	
		Catherine Rausenberger February 21,					21, 2008	7:50 Ам			
	Examin	er	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death			4c. County of Death		
	Contract Contract					Tows	on If Under 24 Hrs.	10.01.4511	Baltimore		
	Funeral Director		,	7. Age (In yrs. la		Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)	
L		To Be Completed by Funeral Director	Usual Residence of Decedent	72	-			02/06/19	16 Lou	isiana	
	yland yland		10a. State 10b. County		Town or Lo	cation				10d. Inside City Limits	
	Mar a-f st		MD. Baltimo	re	Tows	on				1 ∐ Yes 2 X No	
	be filed within 72 hours after death with the Maryland Hylgine. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Co	untry?	
5-0036			507 Dogwood La	ne		2128	6		USA		
			11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:			 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2∑ No Specify: 			14. Race - Ame Black, Whit		
	or i								Specify: Wh		
	hour tural		15. Decedent's Edu		16a Decer	dent's Usual Occup	nation		16b. Kind of Business/		
Ç	in 72 n "nat Aedica		(Specify only highest grade	e completed)	(Give life. L	kind of work done DO NOT use retire	during most of word d)	kina 1	Piper & Mar		
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9	be filed tal Hygi d other event, til		17. Father's Name (First, Middle, Last)		-		18. Mother's Nam	e (First, Middle, N	Maiden Surname)		
yland			James Garcia				France	s Dudeck			
Mar	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Ty	. '					, City or Town, State, 2		
e, e	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Connie Garrique				d Court		m, MD. 2123		
9	e = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	ace of Dispo metery, crer	sition (Name of matory or other pla _Valley	ce) 02/	DE /00	20c. Location - City or		
	: Pages tment of tant: If It jury or o		4 Donation 5 ☐ Other (Specify)	Mem		Camala	- '		Timonium, M		
Baitimor	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	€ V	Ę	Name and Addre	neral_çl	napel & Cr	emation Ser e, Maryland	viœs	
V	40240		7 Ducy William	Draug.]86	800 Har	iora ka	Parkvill	e, Maryland	21234	
		Examiner	23a. Part1. Ent if he disease, or comples ock, or he art failure. List only or	e cause on each line.					est,	Approximate Interval Between Onset and Death	
	Physician /Medical		Imm diate Cause (Final di-ease or condition resulting in death)	Schemi	c C	wdim	y sp. stry			DAYS	
	Examiner		Due to (or as a consequence of):							, _	
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	uted J ansit		Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events								
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	ntifica ng ph as th	Jed	IS SEMANS.								
POX	th ce tendir r use	sician/Medical	IF FEMALE: 23b. Was decedent pregnant	Ectopic pregnanc	v		23d. Date of delivery				
7	e dea he at ied fo		4□Pregnant at time of death 5□Other (specify)						Month	nth Day Year	
7	d by t	Physi	9 Unknow		tinn in the co		and Death	00- Did 4-1			
Š,	w requires that the c been signed by the should be detached	þ	Part II. Other significant conditions con	Anna Lesik	ang in the di	ndenying cause gi	ren in Part i.	236. Did tot	pacco use contribute to es 2 No 3 □ Pi	robably 4 Dunknown	
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ě	elaw hasb je2sh							24a. Was a autops	v prior to	topsy findings available completion of cause of	
<u> </u>	To the Hospital or Attending Physician: The law within 24 hours after death. The tris certificete has to the Funeral Director: After this certificete has to completely filled in by the funeral director, page 2 s							perform 1□ Yes 2	ned? death? 2DkNo 1 □ Yes	2 🗆 No	
VItal			25. Was case referred to medical examiner?	lospital:		ot all box Ott		th (Check only on		1	
DIVISION OF		- T	1 Yes 2000 You	1	R/Outpatien 28b. Time of	IL 3 DOA	4 ☐ Nursing H		ence 6 Other (Spe	citylospeu	
	nding th. : Afte s fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2⊟No	200. 2000.150 110	injury occurred		
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5	s afte	Certification:	4 🗆 Hornicide	building, etc. (Specify)				City or Town	n, State)		
	hour hour uners		29a. Certifier (Check only 2 Medical Exami	sician: To the best of my know	ledge, death	h occurred at the ti	me, date and place	, and due to the ca	ause(s) and manner as	s stated.	
	the H nin 24 the F rplete	Medical	one)	ner: On the basis of examination end manner stated.	on and/or in			rred at the time, d	ate and place, and due	e to the cause(s)	
	vitl To	2	29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)		
			- your	つ		15	0205	F	resourcy 2	1 2008	
10	7		30. Name and address of person who co				a 82 -		mp 2120	17/	
K	Sta	†a	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		vinne	is st	DWIN	no aa	7	
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Registrar

FEB 2 6 2008 Januar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 23 tnna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAUTIMORE BALTI MORE Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 200 F Months Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omemak 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Rd. MD 21234 altimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State on (envitory 2)27/08 BALTIMORE, MD 22. Name and Address of acility & Co Horford Rd, Full more MD 2123 4 Donation 5 Dother (Specify) 21. Signature/of Funeral Service Licenses Evans Funeral Chapel & Cremation Services Parkville complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each li 23a. Part1. Enter the disease, shock, or heart failure. 1 Immediate Cause (Find disease or condition resulting in death) **Physician** mml /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence o Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2**X**No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar

State

29b. Signature and title of sertifier

31. Date filed (Month, Day, Year)

6331

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Below Rd Baltonne MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Dav **Physician** 5:40 AM Mary L. Rosenthal 24, February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 227-14-9348 Director 12/26/19 20 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director MD. Baltimore Parkville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 9014 Forest Road 21234 USA "natural", or Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify Specify: White Widowed 4 □ Divorced ear or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nationwide Insurance than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Switch Board Operator Commenv 12 77 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cyrus Bain Clark Leah Delachine Toleman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Pericles Dr. Bel Air, Maryland 21015 Leah Lynch/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Weteran Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/29/08 Owings Mill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 21. Sig ture of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. In liate Cause (Final disease or condition) 8800 Harford Road Parkville, MD 21234 **Physician** metastaho resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural within 24 hours after uses... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

10 4

Helen M. Gordon 6565

State 31. Date filed (Month, Day, Year) 32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

N

& Sparke

Charles

D00519210

St Baltman MD

24,2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05787 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Bernard G. Renz 1:30 A.M 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Pickersgill Retirement Community Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 91 Yrs. Months Days Hours Min. (Month, Day, Year) 8/20/1916 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** \$**©**M 2□ F 185-07-6409 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, the Medical Expiration must be notified at Baltimore Maryland Towson 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 615 Chestnut Avenue 21204 of America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No White Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Met Life Insurance 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be file partment of Health and Mental Hypertent: If item 27 is marked oth y injury or other traumatic event Francis George Renz Elizabeth Rettiq 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13909 Fox Land Road Phoenix, Maryland 21131 Kathleen R. Mohre/ daughter 20b. Place of Disposition (Name of cemptery, crematory or other place)
Evans Funeral
Chapel- Bel Air 20c. Location - City or Town, State 20a. Method of Disposition Date february 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 26, 2008 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Importe
any njt 21. Signature of Funeral Service Licenses reaceful Aditernatives Funeral & Cremation Ctr., P.A. 2325 York Road Timenium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) ale ans Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medicai for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🖸 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was sere and to medical examiner? Be filled in by the funeral director 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending 5 Pending 1 ANatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29b. Signature and title of dertifier no) -6 N-Charles St. Galts. My 21204 ess of person who completed cause of death (Item 23a) (Type, Print) 82. Registrar's Signature 31-Date filed (Month, Day, Year) State FEB 2 6 2008 Registrar

Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State Of Ivial yie		Certificate of I			eg. No. 200	8 05788	
JB)	Physicia	1. Decedent's Name (First, Middle, Last) Physician George Joseph Rottman, St						2. Date of Deat Month	Dav Ye		
/Medic Examin			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death				February	7 23 20 4c. County of D			
Examin			1116 W. Hamburg	Balti	more	n/a					
×	Funeral Director		Social Security Number 6. Sex 1 Sex 1 Sex 1 Sex 218-48-2514 60 Y			Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/29/1	Birth 9. Birthplace (State or Foreign Country)		
Baitimore, Maryland 21215-0036	/land ow at		Usual Residence of Decedent 10a. State								
	e Mary a-f sh tifled	ctor	Maryland n/a Baltimore 1 1 1/Yes 2 1 N						1 Yes 2 □ No		
	th with the 23a or 28 ast be no	al Director	10e. Street and Number 1116 W. Hamburg	Street		10f. Zip Code 21230		1	Og. Citizen of What United S		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	To Be Completed by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates:	U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Decify Yes or No- Decify Yes		merican Indian, Vhite, etc. White	
	thin 72 ho e. an "natur Medical		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of world)	king	16b. Kind of Busine	ess/Industry	
	filed wit Hygien other the		12 17. Father's Name (<i>First, Middle, Last</i>)			Truck Dr		ne (First, Middle, M		ortation	
	uld be Mental Irked (George Russ	ell Rottman			Flore	nce Cath	erine Sm:	ith	
	2 short and half		19a. Informant's Name/Relationship (**	1	Mailing Address (Street			-	te, Zip Code)	
	f and Health Im 27 Ther tr		Mrs. Dawn A. Rott			6 West Hamb	ourg Stre		more, MD 20c. Location - City	21230	
	t. Pages the transport of the transport		1 Buriat 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification	Removal from State	cemetery,	ciematory or other place ille Vet. (Cem. 2/29			le, Maryland	
g	permi Depar Impor any Ir		21. Signature of Funeral Service Licer		- 0	22. Name and Addre Hubbard I 4107 Will	Funeral H Kens Aven	ome, Inc ue Balt	imore, M	21229	
	Physician /Medical Examiner	ed by Physician/Medical Examiner	23a. Part1. Enter the disease, of comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CARDIDP Due to (or as a cons	ULM equence of		ARRE:	ST		Approximate Interval Between Onset and Death	
Hecords, P.O. Box 68/60,	rificate be executed ng physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Poly A Due to (or as a cons d.	equence of	HRITIS					
	th certifica tending ph r use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre		3 Ectopic pregnance	<i>y</i>		23d. Date of		
	t the death by the atten ached for u		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o	of death	5 Other (specify)			Month	Day Year	
	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ ★6 3 ☐ Probably 4 ☐ Unknown		
	The lar ate has page 2	Completed						24a. Was a autops perfore 1∐ Yes	n 24b. Wer sy prior deat 2 No 1		
Vital	Physician: this certific	Be (25. Was case referred to medical examiner?	Hospital:		otiont 3 DOA Oth		th (Check only on			
0 0	Physral di	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outp	atient 3 DOA	4 LI Nursing H	_	ence 6 Other (Specify)	
	Attending F r death. ector: After by the funera	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,		ury Wor	k? Yes 2∐No		,,		
	of or Attend after death. Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - Abuilding, etc. (Spe	t home, farn ecify)	n, street, factory, office		28f. Location (St City or Town	reet and Number on, State)	r Rural Route Number,	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Gleck only one) 192 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 293 Certifier (Gleck only one) 294 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th within To th comp	Me	296. Signature and title of certifier			29c. Licens			9d. Date signed (M		
)			(19)/LU	16 down		D4	2041		2/26/0	8	
i	117		30. Name and address diperson who	completed cause of death (I	_	ype, Print)	hic U.	111200	^h1 1	ON MO	
O42041 2/26/08 30 Name and address glyperson who dempleted cause of death (Item 23a) (Type, Print) ALEGADO FLI B. M.O. 4115 Ritchie Hwy. 13rookun Park MD State Begistrar 31. Date filed (Mogth, Day, Year) 2008 32. Registrar's Signature 21225							21225				
	Registr	αī		1							

			State of Maryland / Dep 1 - State Registrar Co	partment of Health ar e <i>rtificate of Death</i>	nd Mental I		211118	05789
			Decedent's Name (First, Middle, Last)	or mouto or Boutin	2. Date o	Reg. N	10.6 0 0 0	3. Time of Death
	Physicia /Medic		Charles Dimino Reed		Febru	arv :	21, 2008	10:43 A.M
	Examin	der	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of I			c. County of Death	1 - 1 - 1 - 1 - 1
		55	Suburban Hospital	Bethesda			Montgomer	
	Funeral		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Months Days Hours	Min. (Month	, Day, Yea	r) 9. Birthp	place (State or Foreign ntry)
	Director		220-38-4892 64 Yrs. Usual Residence of Decedent		June	19,	1943 New	York
	how at		10a. State 10b. County 10c. City, Town or	Location			1	0d. Inside City Limits
	e Ma Ba-f s	Director	Maryland Montgomery Wheaton					1 ☐ Yes 2 ☑ No
	vith th		10e. Street and Number	10f. Zip Code			Citizen of What Cour	,
	eath v	Funeral	2311 Arcola Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13	20902	n? /Specify Ves o		ted States	
	fter d r item iner	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I 	Puerto Rican, etc.)	Black, White,	
5-0036	J within 72 hours after death with the Maryland jens. Jens. Tran. Trans.	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1964–69	1 ☐ Yes 2 🛣 No Specify:			Specify: Wh:	ite
	72 hc 'natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most o b. DO NOT use retired)	of working	16b.	Kind of Business/In	dustry
12	within ane. than ' the Me	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) nobile Damage Ap		Se.	lf Employe	a đ
12 p	other in Maic	ပ္ပို	17. Father's Name (First, Middle, Last)		s Name (First, Mid			<u> </u>
Maryland	ld be ental ked o	To Be	James P. Reed	Fae L	. Dimino	,	,	
ar∠	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number	or Rural Route N	ımber, City	or Town, State, Zip	Code)
	es 1 and 2 should be filed of Health and Mental Hygis of Health and St. is marked other ir other traumatic event, the			21 Eagles Nest C	t., Apt.	М, (Germantown	n, MD 20874
altımore,	ges 1 f of He if Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	position (Name of rematory or other place)	bruary 2	9 20c.	Location - City or To	own, State
	t. Partmen tant:		4 □ Donation 5 □ Other (Specify) Montgomery	Crematorium, Inc.		-	hesda, Ma	•
ga	permit. Pages Department of H Important: If Ite any Injury or ot once.			22, Name and Address of Facility Robert A. Pumphre 300 W. Montgomer				
П	7		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				2220, 110	Approximate Interval Between
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	/Medical Examiner		Due to (or as a consequence of):	9				
	^	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ection				
	uted d ansit	Examine	Cause. Enter Underlying Cause (Disease on signry that initiated events C. Thrombocytopenia					
Ď	an and		resulting in death) Last C. Due to (or as a consequence of):					
09/89	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	d					
_	ertific ding p	Mec	IF FEMALE:					
ROX	death certi e attending id for use a	Physician/M	III tile past 12 months:	B Ectopic pregnancy Country (specify)			23d. Date of delive Month	ery Day Year
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Vital Records,	E & OI	Completed				Vas an	24b. Were auto	psy findings available mpletion of cause of
ř =	sician: The la certificate ha irector, page 2	Som				erformed?	death?	2 □ No
VITA	Physician: r this certific ral director,	Be (25. Was case referred to medical examiner?		f Death (Check o	nly one)		
0	≥ 's b	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time				6 ☐Other (Specif	ý)
	ing After une	tion:	1 🛣 Natural 5 □ Pending (Month, Day Year) Injury			ibe now in	jury occurred	
IVISION	Attending r death. ector: After by the funer	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,	F4 F4	28f. Location	on (Street	and Number or Rura	al Route Number,
É	s after	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City of	Town, Sta	ate)	
	e Hospital or Attend 124 hours after death 16 Funeral Director. /	Medical (29a. Certifier Check only 2 Medical Examiner: On the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.					
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	21	29d. [Date signed (Month,	Day, Year)
	~		Mu / Germ Lews.	- D006518	8à	12	121108	
10	iti		30. Name and address of person who completed cause of death (Item 23a) (Typ Sima Nourani Zenuz, M.D., 8600 Old G		Rethord	a Ma	rvland 20	1814
	Sta	te			Detnesa	a, ric	ryrand 20	7014
3	Registr	_	31. Date filed (Month, Day, Year) FEB 2 6 2008 32. Registrar's Signature	Jane L.				

DIMINO

CHARLES

REED,

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARGARET ANNTE RIDGELY February 2008 10:20 pM 24, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 220-16-3671 11, Maryland 85 July 1922 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with nand Mental Hygiene. Is marked other than "natural", or Items 23a or? 15033 Laurel Oaks Lane 20707 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XX 1 Never Married XX Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Grade Clerk Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward McDonald Margaret Kraft ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 soft Health are item 27 is other trau 20707 Maurice Charles Ridgely / spouse 15033 Laurel Oaks Lane Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State Ivy Hill Cemetery 2/29/2008 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperat Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Renal Failure been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【X Xo 24a. Was an certificate has b rector, page 2 sl autopsy 1□ Yes 2 **X X** 0 ospital or Attending Physician: hours after death. uneral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 🂢 🕏 1 XX patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Matural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours at Hospital 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29b. Signature and fitte of sertifier 29d. Date sigyled (Month, Day, Year) D 55861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Munim , MD 10724 Little Patuxent Parkway, Suite 200 Columbia, MD 21044 31. Date filed (Month, Day, X 32. Pagistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 15 2008 Month FEB. HAZEL V. SHELL 9:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARING CORNER ASSISTED LIVING RANDALLSTOWN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/11/1919 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 TF 217-24-6179 Director CAROLINA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 23a or 28a-f show Examiner must be notifled at 1 TYYes 2 □ No N/A Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 MYRTLE **AVENUE** 21217 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 "natural", or Specify:BLACK 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARE PROVIDER SELF-EMPLOYED f Health and Mental Hygir item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STELLA SHADE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE TAYLOR / FRIEND 1404 MYRTLE AVENUE, BALTIMORE, MD 21217 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEW CATHEDRAL CEM. 02/23/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell Funeral Home 21207 21. Signature o Faneral Service Licensee 4600 Liberty Heights Avenue, Baltimore, Md. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cruse (Final disease) condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, frame cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has rector, page 2 performed? 1 ☐ Yes 2□ No or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 1 ☐ Yes 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death I Director: / ed in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in the Hospital EcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifief 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mmands Feny Rd RALPO MO 2122)

Registrar DHMH 17 Rev 1/2001

State

Division or Vital Records, P.O. Box 68760

08-01495

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 State of Maryland / Department of Health and Mental Hygiene Kevin Slater 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day February 21, 2008 0223 hrs Medical Examiner Kevin Slater 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) University Hospital Baltimore N/A8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Min JUN 16 1950 Country) MD Director 57 219-54-9735 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 Yes 2 X No Frederick Mount Airy 23a or 28a-f show notified at once. MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 13024 Old National Pike 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes White Yes 2 X No specify: Specify: I and 2 should be filed within 72 hours after Health and Mental Hygiene. If Yes, Give Year 3 Widowed Divorced ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Chimney Technician Construction 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Steele Margaret G. Slater George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I and 2 should Department of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 2 13024 Old National Pike, Mt. Airy, MD 21771 Rosa Slater - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metro Crematory, 2/22/2008 Baltimore, MD Inc. Donation 5 Other Specify 21. Signature of Funeral Service Licensee Cremation Society of Maryland, In 299 Frederick Road, Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signature of Funeral Service Licensee Steven MDApproximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death a. Head and Neck Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical AMENDED attending physician or use as the burial -UNPENDED law requires that the death certificate be O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g signed by the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) ospital or Attending Physician: hours after death. 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 Residence 6 Other Nursing Home 5 ER/Outpatient 3 DOA 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject fell from a ladder 5 FOUND: 1 Natural 1 ✓ Yes 2 No Pending Director: Feb 20, 2008 1412 hrs Certificati 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 5102 Woodville Road, Mount Airy, MD of the h.
within 24 hous.
"a the Funeral Dr
'ately fille" determined (Specify) Single Family

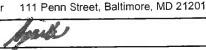
Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) gistrar's Signatur 2008

30. Name and address of person who completed cause of death (Item 23a)

Homicide 29a Certifier 1

29b. Signature and title of certifier

our mi



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 21, 2008

Medical

State

Registrar

one)

and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month /Medical ona 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samar tan If Under 24 Hrs. If Under Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**/**M 2□F Min 212-44-6160 Usual Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☐Yes 2 No must be notified Completed by Funeral Director ALTIMORE TIMOR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 1 and rother than the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be no 2 123 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဥ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Nymber, City of Town, State, Zip Code) 4more 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any Injury or o Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Socred Heart of Jesus lem 26/08 Dundalk, 4 Donation 5 Dother (Specify) 21. Signatu of Funeral Servi A icenses Road, Baltimore, My 0 Chasel+ Cremation stuneral Tarkville e, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Do not enter the mode of dying, such as cardiac or repiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequent Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) signed by the a d be detached for I Yes 2 □ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performa After this certificate ha funeral director, page 21000 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Sign 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

Year)

FEB26

he and address of person who completed cause of death (Item 23a) (Type, Print

2008

				partment of Health and Mental Fertificate of Death	Hygiene 2008 05795
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year
	/Medic	cal	Charles Robert Serio 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jary 23, 2008 9:30 p M
	Examir	ier	Stella Maris	Timonium	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Birth Day, Year) 2,1928 9. Birthplace (State or Foreign Country) Virginia
	Director		217-22-7585 ^{1X) M 2 F} 80 Yrs.	Feb.	2,1928 Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Mary a-f sh	ţoţ	Maryland Baltimore Cockeys	ville	1 □Yes 2♥No
	th the or 28a e not	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wi		45 Silver Fox Court	21030	U.S.A.
	items items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces? 1 □ Weser Married 2 ■ Married 1 ■ Weser Married 2 ■ Married 1 ■ Weser Married 2 ■ Weser Married 1 ■ Weser Married 1 ■ Weser Married 1 ■ Weser Married 1 ■ Weser Married 1 ■ Weser Married 1 ■ Weser Married 2 ■ Weser Married 1 ■ Weser M	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
336	urs af	ğ	1 Never Married 2 Married 1 Mes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
2-0	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show digal Examinar must be notifled at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation te kind of work done during most of working	16b. Kind of Business/Industry
121	I within 72 ho piene. r than "natur the Medical	햩	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired) 1 Estate Broker	Real Estate
12	filed w Hygie ther the	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	
and	be d od o	To Be	Charles R. Serio	Margaret	Dize
Baltimore, Maryland 21215-0036	de E E	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
Z	and 2 lealth a m 27 Is		Virginia M. Serio / Wife 45 9	Silver Fox Court Cockey	ysville,Md. 21030
ore	(h) () >-	M	20a. Method of Disposition ↑☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposeries, cremetery, creme	ematory or other place)	20c. Location - City or Town, State
tim	t. Pag tment tant: ijury		4 Donation 5 Other (Specify) Dulaney	Valley Cem. 2/26/2008	
Bal	permit. Page Department of Important: If any Injury or once.			22. Name and Address of Facility Ruck Towson Funeral Home	1050 York Road
	Physician (Madical		23a. Part1. Enter the disease, or much lions that caused the death. Do not enshow, or heart failure. List not be cause on each line. Immediate Cause (Final disease or condition a. a.	nter the mode of dying, such as cardiac or respirator	ry arrest, Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as consequence of):	3 11-15132	
	12.	ie.	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury		18
	cuted nd ransit	Examiner	that initiated events		
, 0,	cate be executed oblysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):		
8760,	cate b physic the b	dical	d		
. Box 6	eath certifi attending for use as	Physician/Med		Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I 23e F	Did tobacco use contribute to the cause of death?
	w requires the been signed should be d	ted by	Part II. Other significant conditions contributing to death but not resulting in the		☐ Yes 2☐ No 3☐ Probably ♣️☐Unknown
Vital Records,	The lar	Completed		a	Vas an utopsy utopsy enformed? es 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check or	
ō	ding Phys h. After this funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending	of 28c. Injury at 28d. Descri	Residence 6XOther (Specify) HOSPICE ibe how injury occurred
Division	al or Attending safter death. I Director: After d in by the fune	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
	To t Within	W	29b. Signature and title of certifier	29c. Licogse number	29d. Date signed (Month, Day, Year)
	, ,		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	

2+1

9:30 р.ш.

FEBRUARY 23, 2008

CHARLES SERIO

State Registrar

DR. EDDIE NAKHUDA 31. Date filed (Month, Day, Year) FEB 2 6 2008

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 6:17 P^{M} 2008 Sylvia Schweber 16, February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Days Months New York 1 □ M 2 X F 91 March 9, 057-03-5045 **Director** 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane 20852 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the <u>Medical Examiner must</u> once, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No White Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Meyer Siegel Anna Pellman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William I. Schweber / Son 3405 Woolsey Drive, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 21, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Fune Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease Exacerbation Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Unknown if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed Urinary Tract Infection Unknown and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy this certificate 1 Yes 2 X No 1 Yes 2 No ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient မ 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Yes 2 No I Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records, within 24 hours af

To the Funeral D

completely filled in Hospital

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

29c. License number

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

February 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11119 Rockville Pike, #401, Rockville, Maryland 20852 Petek Donmez, M.D. 31. Date filed (Month

ORIGINAL

Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #20a-c&22 Per FH G877 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Billy Strickler February 16, 2008 7:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Bayview Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 82 Director 220-12-9944 July 11, 1925 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2√ No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3814 North Point Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Armed Folces.
1 ∑Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify. Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) timekeeper steel mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Raymond Strickler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Strickler/son 7829E Collinham Drive Dundalk, MD 21222 20a. Method of Disposition
1 △ Fundamental August 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 ₩ Other (Specify) in state 3/17/2008 Balto, City, MD Lawn Cemetery 21. Signature of Funeral Service Lice Ronald S 22. Name and Address of Facility
Bruzdzinski Funer wade Home P.A. 1407 (MD 21221)
such as cardiac or respiral ory arres. Old Eastern that caused the death. Do not enter the mode 23a. Par I. Enter the disease, or complete ship k, or heart failure. List only one commediate Cause (Fig.) Approximate interval Between Onset and D Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending hybridian and Due to (or as a consequence of): division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown s been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 📋 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature of depth (Nem 200) (Type Fortill - A RITCHIE HIGHWAY) NO 32. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 16. **Physician** 2008 Pearl Shipman Sarah 8:51 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8708 Dangerfield Place Prince George's Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 247 66 4550 67 Director 14. 1941 South Carolina April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Marylan Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examilner must be notified at 10a. State 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8708 Dangerfield Place 20735 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married Married Specify: White 2□No XX 1 🗌 Yes þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 d 2 should be filed w h and Mental Hygie 7 is marked other tl Cook School traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Alonzo Willie Emma Leona Shumpert 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Thomas Y. Shipman (Husband) 8708 Dangerfield Place, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 21, 2008 Clinton, Maryland rematory 2. Tame an Address of Facility Lee Funeral Home, inc 663301d uneral Ser 21. Signature of Alexandria Ferry Road, Clinton, MD 20735 er the di heart fe Approximate Interval Between Onset and Death 23a. Part1. shock, e, or complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Ty Sive Cardiovascul Physician disease or condition resulting in death) /Medical Due to (or as consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2☐No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 🔲 Inpatient ၉ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician: the Hospital

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

rector DHA 7582 Annapolis

29d. Date signed (Month, Day, Year)

		- 1	For Amend Items 24	ta, 27 per dr.	nd / Department of H , 2876 02/26/03d	beath	Reg. No.	8 05800
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	/Medic Examin	_	la. Facility Name (If not institution, give			r Location of Death	4c. County of De	
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-	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Hours Min. (Mpg)	of Birth 9. B	irthplace (State or Foreign Country) unk
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Kuneral Service Licens		22. Name and Addr	ess of Facility Comy Board 655	W. Baltimore	Street
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or Vital Records, P.O. Box 6	ng Physician: The law requires that the death certificater this certificate has been signed by the attending princral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf preg 1	gnancy stal death 3 Ectopic pregnan f death 5 Other (specify) esulting in the underlying cause g A A A A A A A A A A A A A A A A A A	24a 24a 26. Place of Death (Check of ther: 4 \(\text{ Nursing Home } 5 \) 28d. Des ork? Yes 2 \(\text{ No } \) e 28f. Lock City	Month Did tobacco use contribut The second of the cause (s) and manned to the cause	Day Year e to the cause of death? Probably 4 □Unknow e autopsy findings available to completion of cause of ?? Yes 2 □ No Specify) Fraural Route Number, er as stated.
or Vital Records, P.O. Box 6	Physician: The law requires that the death certificate has been signed by the attending paral director, page 2 should be detached for use as	To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf preg 1	gnancy stal death 3 Ectopic pregnan f death 5 Other (specify) esulting in the underlying cause g	24a 24a 26. Place of Death (Check of ther: 4 \(\text{ Nursing Home } 5 \) 28d. Des ork? Yes 2 \(\text{ No } \) e 28f. Lock City	Month Did tobacco use contribut The second of the cause (s) and manned to the cause	e to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of h? Yes 2 No Specify) r Rural Route Number, er as stated. due to the cause(s)

29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
FEB 2 6 2008

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24:50 M Slicher 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown HOSPITAL Baltimore NORTHWEST 8. Date of Birth (Month, Day, Ye. May 16, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 92 Months Hours 220-46-1180 1915 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show at ar than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1 ☐ Yes 2 No Directo Maryland Baltimore Westowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 639 North Bend Road 21229 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any hiury or other traumatic event, the Medical Examinea 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Schluderberg Dorothy Unknown မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Fenwick / Daughter 212 Church Road Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 02/27/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licensee Dass 5311 Fdmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Pulmonani Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Hospital: 1 patient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DDA မှ 28a. Date of Injury (Month, Day Year) 28b, Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 | Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide . in critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 0066357 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HUSPITAL IZEDDIVARI VENILATA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** len 400 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death Examiner listown 8. Date of Birth (Month, Day, Year) Feb. 21, 19 9. Birthplace Country) Age (In vrs. last birthday) **Funeral** Months Days Director 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apti Funeral 12 Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. 2 3 ☐ Widowed 4 🂢 Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) esman Important: If item 27 is marked other any injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City of Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 21. Signature of Funeral Service Licensee neral th Ave. W. Nor Balto. 23a. Part /. sh /k Inter the dis was or heart fail se, or complications in a cause time death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 560817 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 0 in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ signed t int conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 🗌 Yes Completed amal fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has cordiumyonatri autopsy certificate 1∐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 2 Hospital: P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 10 Spic @ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred : After Certification: 5 Pending investigation Injury within 24 hours after www.

To the Funeral Director: After which filled in by the fur 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

P.O. Box 68760, Records, or Vital the

State Registrar

31. Date filed (Month, Day, Year) FEB 2 2008

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print) Clistentum, MD 2113 6 MICHELIUN 32. Registrar's Signature

and manner stated.

29c. License number

D0060680

29d. Date signed (Month, Day, Year)

15

2000

			. 104.00	State of Maryla	nd / Departme	ent of Health and	Mental Hy	giene o o o	
			1 - State Registrar			ate of Death		Reg. No. 200 {	3 05803
	Physici	×	1. Decedent's Name (First, Middle, La	st)			2. Date of De	ath Day Year	3. Time of Death
1	/Medi		Dorothy	Smith			Februa	iry 16,200	8 12:30"
	Examir	ner	4a. Facility Name (If not institution, giv	ONERNY W	1 11	ty, Town, or Location of De		4c. County of Dea	m
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday) If Und	der 1 Year If Under 24 H		th 9. Bir	thplace (State or Foreign
	Director		X11-44-128U	OM 2X F 97	Yrs. Month	ns Days Hours M	Nov. 2	8,1910 M	aryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
	Mary -feh	tor	MD NI	a	Baltic	nore.			1 Yes 2 No
	or 288	Funeral Director	10e. Street and Number		A 10f.	Zip Code		10g. Citizen of What C	ountry?
	ath wi	rai	1100 Penns	zylvania 7	Are	2120		US/	4
	ter de Itame	-une	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S. 13. Was De If Yes, s	cedent <i>o</i> f Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Ame Black, Whi	
920	el', or	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: B	lack
215-0036	within 72 hours after death with the Maryland ane. than "naturel", or iteme 23a or 28a-f ehow ta Madical Exeminer must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	Jucation ade completed)	16a. Decedent's U (Give kind of	suaf Occupation work done during most of v use retired)	vorking	16b. Kind of Business	/Industry
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	Hygid other	Be Co	17. Father's Name (First, Middle, Last,		Domes		lame (First, Middle,	Maiden Sumame)	iamilies
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Maryland	2 should and Men is marke raumatic	ľ	19a. Informant's Name/Relationship (D 1 1	19b. Mailing Addre	ess (Street and Number or	Rural Route Numbe	er, City or Town, State,	Zip Code)
_	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "netural", or itame 23e or 28e-f ehow other traumatic event, Ire Medical Exemilier must be notified at		20a. Method of Disposition	Kobinson	Place of Disposition (/	Ketlaw K	d. Bal	20c. Location - City or	Town State
υor	Pages nent of int: If it		1 Burial 2 Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, crematory of	r other place)	21/2000	Rath	Md
Baltimore,	permit. Page Department of mportent: If any injury or once.		21. Signature of Funeral Service Lice		22. Name	and A less of Facility	T. 1000	Daction	20
<u> </u>	88 3 8		+ tatelle &	. Herris X	Mr. 2225	PWWAFF	Ave. E	al Home, I	21216
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.		, •	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
25	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Vasma	derestiq			
	Examiner			Due to (or as a conse	equence or):				
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Вох	leath certificat attending phy I for use as th	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of pregr	tal death 3 Ectopic			23d. Date of de Month	livery Day Year
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ords	w require been sig should b						10'	Yes 2 □ No 3 □ P	robably 4 Noknown
of Vital Records,	law re	Completed					24a. Was	osy prior to	utopsy findings available completion of cause of
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	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		now injury occurred	ocity)
Sior	Attending I r death. ector; After by the funer	atio	1 Auturaf 5 Pending 12 Accident investigation	n	Injury M	1 Yes 2 No			
Division	i i te	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, street, lact cify)	ory, office	28f. Location (S City or To	Street and Number or R vn, State)	ural Route Number,
_	spitai		29a. Certifier 1 Certifying Ph	ysician: To the best of my kr	nowledge, death occurre	ed at the time, date and pla	ice, and due to the	cause(s) and manner a	s stated.
	To the Hospital or Atten within 24 hours effer deat To the Funeral Director; completely filled in by the	Medicai	(Check only 2 Medical Exar	niner: On the basis of examin and manner stated.	nation and/or invastigati	on, in my opinion, death or	curred at the time,	date and place, and du	e to the cause(s)
	To To	2	29b. Signature and title of certifier	44.5		29c. License number		29d. Date signed (Mon	th, Day, Year)
,	0		Playman M	WW MD	m 22a) /T 7.1.1	DA 1643		2/19/08	
	1		30. Name and address of person who Rhy Mand Miller	completed cause of death (Ite 25 Mari Smur 2. Registrar's Sign	Simile 200	Reinerlows	MD 2	1136	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	Pature Search				
4.9	Registr	ar	FEB 2 6 200	10 September 10	1				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SALAMONY **Physician** LILLIAN , M. , 2008 2: 28 PM 02 /Medical 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MERCY MEDICAL CENTER N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 82 yrs 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □XF Director 217-22-4344 Yrs MAR. 17, 1925 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Exertiner must be notified at MD. HARFORD Director **JOPPA** 1 ☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 418 JOPPA FARM ROAD Funeral 21085 death UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ö þ 1 ☐ Yes 2 🔯 No 3

Widowed 4 □ Divorced Specify: WHITE "natural" ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) 7TH 0 HOMEMAKER OWN HOME marked other 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file iment of Health and Mental Highert: If item 27 is marked other: 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE STROBLE ANNA L. GIBSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT T. SALAMONY, SR. 418 JOPPA FARM ROAD, JOPPA, MARYLAND 21085 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 HOLLY HILL CEMETERY 2/20/2008 BALTIMORE, MARYLAND permit.
Departrimporte
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND ~ 23a. Part1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiomyopathy disease or condition resulting in death) unknown /Medical Examiner unknown kidney disease hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine nding physicien and use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical ste has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy perform this certificate 1 Yes : After this certifical funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 ☐ Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: the 6 Could not be 3 ☐ Suicide ģ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Direct 4 T Homicide filled in t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/15/2008 MD P18605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Department of Marie City 22 S. Greene St. Balthmore, MD 21201 MANJULA V. GUNAWARDANE, MD 31. Date filed (Month, Day, Year) State Registrar FEB 2 6

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 aa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Loving-Living Assisted Living Rosedale Baltimore County If Under 1 Year | if Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 9/8 Baltimore, MD. 213-12-2804 Months Days Hours Min. 1 □ M 2 F 89 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore County Rosedale Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 United States 5822 Shady Spring Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Marvland Match Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Elliott Gus Huber 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Pine Chip Court Baltimore, Maryland 21236 Mrs. Janet L. Carroll (2nd Cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Eremation 3 ☐ Removal from State Feb. 23,2008 Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
eaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License Approximate Interval Between Onset and Death Ran 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscientia **Physician** 10 Year resulting in death) /Medical Due to (or as a consequence of): Examiner oronam if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque ce of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last and burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending property for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9∏Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 21 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTEC 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0055992 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 6730 Hollbird Baltimore leburah (6010 1)0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

29b. Signature and title of certifier

Sund Gasta
31. Date filed (Month, Day Year)
FEB 2 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

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725

32. Registrar's Signature

Kent

29c. License number

00033250

29d. Date signed (Month, Day, Year)

Avenue Cumberland, maryland 21502

el 24 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ance 6:34 PM Emore 08 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner VA. Medical Baltimere saltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1₩ 2□F Yrs. Dec 19, 1931 Tennessee 409-50-1689 Director 76 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No Director MD Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be 150 E. Main Street #301 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 152-57 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: white <u>ک</u> 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than ury or other traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event, the Meron or the traumatic event 12 US Government technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Richard Miles Vance Clara Pauline Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 150 E. Main Street #301 Elkton, MD Shirley Vance/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Syntum | Feneral Service Linusee
Wadd: Prector 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street <u>21</u>201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** Arrest hour /Medical Due to (or as a consequence of): Mucous Plugging Examine hour Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 1 week law requires that the death certificate be executed neumonia and Due to (or as a consequence of): burial attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 Yes 2 No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Myocardial Inforction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 2 has e 2 page certificate No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral (27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1) Natural (Month, Day Year) Injury 5 Pending investigation within 24 hours affer use...
To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21146 2008 20 February MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD Bernidelle C. 10 North greene street Guston, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

or Vital Records,

Division

Registrar DHMH 17 Rev 1/2001 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mer 1. State Amend Item 29d per dr., g876, 92/26/08dbb Death	ntal Hygien	9	05000
			Decedent's Name (First, Middle, Last) 2.	. Date of Death _Month Da	Z U U U	3. Time of Death
£	Physici /Medic		Benjamin JOHN WOODSON R	eb, 10,	2008	19:15 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baitmore	140	County of Death	-
20	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year	0 8:45-	lace (State or Foreign
	Director		212-20-8112 20 11s.	ept. 5, 1	124 ma	ryland_
	/land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	e Man la-f sh tiffed	ctor	md. NA Baitimore			1 Yes 2 No
	with the	Director	10e. Street and Number 141 N. Monastery St. 21229	10g. C	tizen of What Coul	ntry?
	heath v	Funeral	12 Was Decedent Eyer in U.S. 13 Was Decedent of Hispanic Origin? (Specific	fy Yes or No-	14. Race - Americ	
5-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, White,	lACIC_
2-0	72 ho "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)		Kind of Business/In	
121	ted within lygiene. her than nt, the Me	dwo	Elementary/Secondary (0-12) College (1-4or 5+) Custo can	<i>t</i>	Busin	ess
פַּ		BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (F	First, Middle, Maide	Surname)	
<u> </u>		P	Benjamin Wood Son Heles		aige	- Code)
Maryland 2	d the straight straig		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural F	2	1	21216
	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cometery greenatory or other place)		ocation - City or T	
<u>=</u>	Par Ten ant: ury		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crown Svile Vet Cem 2-15	5-08 CA	our svill	e, mD.
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	70 Fred fith. Bo	HILTON M	d,21229
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	Physician /Medical		Immedia Cause (Final disease or condition resulting in death) a. Drop Arc Root Difference of the control of th	800	18	
	Examiner		n M			
	₽ .≒	iner	Se trentially list conditions if any, leading to immediate cause. Enter Underlying			
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98760	ificate be executed g physician and as the burial-transit		d			
_		Medical	IF FEMALE:			-
. Box	The law requires that the death certifitute has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of deliv Month	ery Day Year
<u>Р</u>	at the d by th etache	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacco	use contribute to	the cause of death?
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900 000	e law red has bee je 2 shou	Completed		24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
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	siclan; certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	1. /	6 □Other (Spec	54.1
0	ding Phys h. After this funeral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	d. Describe how in		
Sion	tending Fleath. tor: After the funer	atio	2 Accident No 1 Yes 2 No			
Division or	or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28	Bf. Location (Street City or Town, Sta	and Number or Ru ite)	al Route Number,
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director; After this certifics completely filled in by the funeral director, I	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month 2/11/2008	
)		1	Jawren Will MA DOOZDE	994	1 300	09
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1//		
9	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	VT		
	Regist		FEB 2 6 2008			

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

William T. Tanner, M.D.

FEB 2 6 2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

11701 Livingston Road, Fort Washington, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Wheeler Willie 3:11 AM February 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner BALTIMORE Under 1 Year | If Under 24 Hrs. AGNES HOSPITAL If Under 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Hours 215-76-8911 Director Usual Residence of Decedent 10b. County works, 10c. City, Town or Location 10d, Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Mansiera 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wilkers 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ionstruction Laborer 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If item 27 Is marked oth y injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mor 20c Location - Ony or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hepatic encephalopath 4 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CITTHOSI ECUTS Sequentially list conditions, if any, Loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Records, P.O. 1 Yes 2 □ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate 2 ☐ No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours aner with To the Funeral Director: Af 2 Accident 1 Tes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D+1843 February 21 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

REED

FEB

2008 6

31. Date filed (Month, Day, Year)

900 CATON AVE

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BARBARA WELLS-FREYMAN FEBRUARY 21 11:20 P ^M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 07/08/1947) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF 091-40-0058 60 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 X No MD Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 830 TEMPLECLIFF ROAD 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. m 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL ASSISTANT HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY **ASHMAN** ROSE 0 CUSHNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 TEMPLECLIFF ROAD, Health em 27 WAYNE FREYMAN / HUSBAND BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation DRUID RIDGE CEMETARY 02/25/2008 | BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD art . Enter the disease, or complications by aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛚 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 1/12504 5 c. F 2 . 22 . 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 2121

P.O. Box 68760

or Vital Records,

Division

WELLS-FREYMAN

BARBARA

FEBRUARY

The law requires that the death certificate be executed physician and s the burial-transi Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Physician

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Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner	Sequentially list conditions, if any leadin; to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)				
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3⊟Ectopio	c pregnancy (specify)		23d. Date of delivery Month Day Year
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To E	1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
rtion: 7	27. Manner of Death 1 ₭ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fact fy)	tory, office	28f. Location (Street City or Town, Ste	and Number or Rural Route Number, ate)
Medical Certification:		vsician: To the best of my kno iner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier			29c. License number	29d. [Date signed (Month, Day, Year)
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	30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, Print)			
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te ar	31. Date filed (Month, Day, Year) FEB 2 6	32. Registrar's Signa	ature			

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 20 2008 1:50 A Feb. Betty Lou Zelinka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville Jnder1Year | If Under24 Hrs. Baltimore MD Masonic Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√□ F Yrs. Dec. 16 1932 Director MD 213-28-2024 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2√☐ No Director Cockeysville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 USA 300 International Circle Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Electric Assembly Line Tech. 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanette M. Smith George W. Hinks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Manor Knoll Ct., Baldwin, MD 21013 Karen Weatherholtz/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition /23/08 1 N Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 21. Signature of Fun 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Ad Due to (or as a consequence of): ALZHaimar'S Diseese yeurs **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: death. within 24 hours after death To the Funeral Director:

autopsy performed? Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

death? 1 ☐ Yes

2 **X** No

Registrar

Medical

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3508 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:50 A M -UTHER 2008 February 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Harford 934 Coen Road, Street 8. Date of Birth (Month, Day, Year) 6, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. **1** M 2 □ F Days Maryland 213-28-7977 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits MD 1 ☐ Yes 2 No Director Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō be USA 934 Coen Road 21154-1112 item 27 Is marked other than "natural", or items 23s other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1224 es 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 12√2 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married XXMarried 1 ☐ Yes 2 ☐ No Specify: à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 3altimore, Maryland 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Plasterer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Genevieve Mayes John Henry Appel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other any injury or other and injury or other any injury or other and injury or other a Shirley Jo Appel / Wife 934 Coen Road, Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Grdn. 2-25-08 Bel Air, Maryland 21. Signatur@ of Funeral Service License 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oncrec disease or condition resulting in death) cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first of the sequence of the se Due to (or as a consequence of): Examine that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending I for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after e Funeral I Hospital Medical 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0028477 PHYSICIAN 21,2008

10+

State Registrar

PHTUIP NOWATPUNIN 602. ATWOOD ROAD BEL ATR
31. Date filed (Month, Day, Year) 32. Registrar's Signature

2008

FEB27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Ma		epartment of F C <i>ertificate of</i>			giene Reg. No.	08	05818
-S2			Decedent's Name (First, Middle,	Last)				2. Date of De Month		Year	3. Time of Death
#	Physici Medie		Robert Frankli					FEBRUAR	7 20	2008	22.52 PM
	Examir	er	4a. Facility Name (If not institution, LINION HOSPITAL	give street and number)	COUNTY	4b. City, Town, o	TO N		4c. County	of Death	
- A4E	Funeral Director		219-34-2487	5. Sex 1 X M 2 □ F	e (In yrs. last birth	day) If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug. 1	th y, Year) 7, 1 938	Coui	olace (State or Foreign ntry) aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
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	th the or 28; e not	Sirec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coul	ntry?
	ath w	ral	61 Boddy Lane	1,2,11			918		USA		and all all and
2-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla Specii	ck, White,	can Indian, etc. nite
2-0	72 hoi natur dical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. [Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of work	ing	16b. Kind of B	lusiness/In	dustry
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d 2	filed within I Hygiene. other than ent, the M	Be Co	17. Father's Name (First, Middle, La	ast)		MECHATIC	18. Mother's Nam	e (First, Middle,			<u>C</u>
Maryland	ould be Mental arked o atlc eve	To B	Theodore (nmn)	Acker			Anna V	irginia	Temple	:	
lar,	2 sho and I Is ma		19a. Informant's Name/Relationshi	(Type. Print)	19b.	Mailing Address (Street	and Number or Rui	al Route Numb	er, City or Town	, State, Zip	Code)
	1 and 2 Health em 27		Theodore Acker /	Son	20b. Place of I	3702 Mill R	oad, Abin	gdon, M	D 21009 20c. Location	- City or To	own State
ğ	Pages nent of h ant: If ite ury or o		1 Bural 2 Cremation	Bemoval from State		Disposition (Name of crematory or other plants of Service C		8-08	Towson	•	
Baltimore,	pernin. Trages I and Department of Health Important: If item 27 any injury or other tr		MARIANIA	censes /	11/	22 Name and Addre				, , ,	.7 =====
<u> </u>	2255		/ NUCLEM	KIM	11/1	1317 Cokes	bury Road	, Abing	don, MD	2100	
	Physician	1	23a. art1 Enter the distate, or shock, or heart failure. List o Immediate Cause (Final disease or condition			TACHYCA		or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of						
1		e	Esquentially list conditions, if any, leading to immediate	- Di -	a consequence of					,	
V	od ansit	Examiner	Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CONG	ESTIVE	HEART FA	ILURE &	XACERB	BATION		
0,	e exectian anurial-tr	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
68760,	ificate be executed I physician and ss the burial-transit	edical	'	d							
	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			ate of deliv	ery Day Year
rds, P.	w requires that is been signed by should be detail	þ	Part II. Other significant condition	s contributing to death b	out not resulting in	he underlying cause giv	ven in Part I.		obacco use con Yes 2 □ No	tribute to t	the cause of death?
Division or Vital Records,	The law recate has bee page 2 shot	Completed						24a. Was auto perfo 1□ Yes	an 24b. psy prmed? 2 7 No	prior to co death?	opsy findings available ompletion of cause of 2 No
/ita	ysiclan: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	1 Inneritals		Tau	26. Place of Deal	h (Check only o	one)		
on or	ding Physiclan: After this certific funeral director,	ion: To	1 Yes 2 No 27. Manuar of Death 1 Natural 5 Pending Investiga	Hospital: 1 Inpation 28a. Date of Inju (Month, Date)	ıry 28b. Ti	ury Wo	4 LI Nursing Ho		dence 6 🗆 Ot how injury occu		fy)
Divisi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of inj	ury - At home, farr ic. (Specify)	n, street, factory, office		28f. Location (City or To		ber or Rur	al Route Number,
	B Hospit 24 hour Funera etely filk	Medical (Physician: To the best caminer: On the basis of and manner st	f examination and						
	To the within To the compli	Me	29b. Signature and title of expline			29c. Licens	/		29d. Date sign		
			· XIII		10		63486		FEBRUA	17,20	7,2008
	4		30. Name and address of person w	106 BOW.	STREET,	ype, Print) ELKTON, MI	21921				
	Sta Regista		31. Date filed (Month, Day, Year)	Registr	ar's Signature	Soul s					

08-01405 Ho

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Howard Brooks		State of Maryland / Department of Health and Certificate of Death	d Mental Hy		, No. 20(08 0581
Physicia	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month February 18		3. Time of Death
Medical Examin	ier	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or	Location of Death		4c. County of Dea	
5		1520 West North Avenue Apt. 203 Baltimore			NI	A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		٠,	` C	irthplace (State or Foreign ountry)
Director		219-38-6287 1 M 2 F 6' Yrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. W		Nov. 26	2,1940	Ma.
any	Ì	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
land f show	ē	Md. N/A Baltimore			0.00	1 Yes 2 No
e Mary or 28a	Director	10e. Street and Number	1	109	g. Citizen of What Co	1
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His				erican Indian, Black,
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban		Rican, etc.)	White, etc.	1
rs after ural",	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupat		work done	Specify: 6	s/Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life.				
5-0036 led within 7 Hygiene. lother that the Medics	팂	8 0 Driver		(F) 1 4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Gemsta	r Wharry Co
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M	Tohoc	,
212 ould be d Menta s marke	다	19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street	et and Number or F	Rural Route Numi	ber, City or Town, Sta	ite, Zip Code)
ore, MD es 1 and 2 sho of Health and If item 27 is		MS Donna DySon 1630 N. Ell 20a. Method of Disposition 20b. Place of Disposition (Name of cer	amont	St, P	20c. Location - City	d. 21216
more, N Pages 1 and tent of Healt int: If item		1 Burial 2 Cremation 3 Removal from State crematory or other place)		9/2008	200: 200ation - Oily	11/ 1/1
Baltimore, Peest 1 a Department of He Important: If it important: If it injury or other It.		4 Donation 5 Other Specify: IVT. Carmel 21/Signature of Funeral Service Licenses 22. Name and Address	s of Facility		Dunaa	IK, Ma.
Balti permit. Departn Imports		Joseph L. Fruss 2222 W.N.	Kuss tu	Bal-	tome, P.A.	216
Physician /Medical		23a FP-rt I. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, failure. List hely one cause on each line.	, such as cardiac o	or respiratory arre	st, shock, or heart	Ápproximate Interval Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death) a. Complications of chronic alcohol abuse Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	amine	if any, leading to immediate Due to (or as a consequence of): causa. Enter Underlying Cause (Disease or injury that initiated				4
ed	Exar	events resulting in death) Last Due to (or as a consequence of):				
execui an and al - tra	dical	d. UNPENDED AMENDED				
68760, certificate be nding physici se as the buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	ery
certification ce	cian/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregna	ancy	Month	Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			to the cause of death?
ds, equires	eted			24a. Was a		autopsy findings available
e law re has b	Completed			autops perfor	med? death	o completion of cause of ? Yes 2 No
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on of ading F h. t. After e funer	on:	(Month, Day,Year)	ury at Work? Yes 2 No	28d. Describe n	low injury occurred	
Division fall or Attendins after death.	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office	building, etc.			Rural Route Number, City
Div pital o ours aff	Certi	4 Homicide determined (Specify)		or Town, St	tate)	
Di To the Hospital of within 24 hours at To the Funeral L	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior	late and place, and	d due to the cause at the time, date a	e(s) and manner as sand place, and due to	tated. the cause(s)
To t With Com	Medi	and manner stated. 29b. Signature and title of certifier 29c. Licens			29d. Date signed (#	
		0.C.	.M.E.		February 19, 2	008
7		30. Name and address of person who completed cause of death (Item (3a)		1004		
2		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Bali 31. Date filed (Month, Day, Year) 32. Registrar's Signature	timore, MD 21	1201		
Sta Regist						
DHWH 17 Rev 1/20 OCME 2006	υT	ORIGINAL			OCME	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend 10f, perFH, C876, 2/27/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 330 AMES 2008 /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death eath enab 5. Social Security Number **Funeral** Date of Birth (Month, Day, Birthplace (State or Poreign Country) Months Days Min. 11**⊘**M 2□F Hours 220 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show freumatic event, the Medical Examiner must be notified at mai 1 Yes 2 No Directo ZNO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ត ric/ 150 Herna 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Alo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 vivorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it of Health and Mental Hygiene. If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Worke NA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be to and Mental I Young 0192 Weaver 19a. Informant's Name/Relationship (Type, Print) _ B. The 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baeto. Kavanna Young 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or 4 □Donation 5 □ Other (Specify) -29 armel 21. Signature of Ponera Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 /Medical Examiner Sagrant by list control if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Be Completed by Physician/Medical 88 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Deatal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□ Unknown 9 ☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: No No P 1 🗌 Yes 1 🗌 Inpatient Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident М within 24 hours after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide to the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

ZCM

istrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 32.

31. Date filed (Month, Day, Year)

Bollon

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per fb 9876 2-27-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 630 AM **Physician** Month Van Bowle 08 02 3 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore NIA Hewth + Rehab | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 1 / 1 / 7 0 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months 1 ☐ M 2 🔀 F 219-94-9268 37 Director ΜD Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 DXYes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with t nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or 1 ary or other traumatic event, the Medical Examiner must be n 602 E. 29th Street 21218 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African
Specify: 1x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self House wife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley C. Bowie Be Carrie Mae Rodgers Doris Clayton Chris A. Heidelberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 602 E. 29th St., Balt., MD Stanley C. Bowie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/25/08 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crem. Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt., 21. Signature of Fungral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired orminal Immuno deficien **Physician** 10 YV resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any Learning cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an page 2 s autopsy perform 1 Yes 2 certificate or Attending Physician; 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1865 nian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) treat 2/20 antan 821 m 206 31. Date filed (Month, Day, Year) istrar's Signature 32. Rt State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

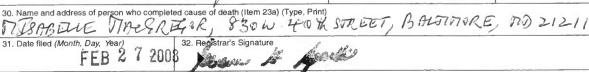
			For State Registrar	State o	f Marylan		artment of I		nd Mental	, ,	ne vo. 2008	05823
	Physici		Decedent's Name (First, Middle, La SHELLEY	st)			BROWNS		2. Date of Month	of Death	Day Year 24 2008	3. Time of Death 6:47P
	/Medic Examir		4a. Facility Name (If not institution, giv		,	CTR.	4b. City, Town, o	or Location of		4	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. S 218-52-2792		7. Age (In yrs. 57		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month		9. Birt	hplace (State or Foreign untry) MD
	ne Maryland 8a-f show otiffed at	Director	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	RE		y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 📉 No
	ath with the 23a or 2 sust be no		10e. Street and Number 6927 DIANA ROAD				10f. Zip Code	21209			Citizen of What Co USA	
5-0036	be filed within 72 hours after death with the Maryland that Hygiene.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 /∆ No ∕e		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		in? (Specify Yes o Puerto Rican, etc	or No- .)	14. Race - Ame Black, White Specify:	
21215-0	d within 72 hu giene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1	i-4or 5+)	(Give life. i	dent's Usual Occuj kind of work done DO NOT use retire	during most (d)		16b.	Kind of Business/	ŕ
Maryland	% a a a	To Be C	17. Father's Name (First, Middle, Last, HERMAN			KAH		ESTE			S	NYDER
e, Mar	es 1 and 2 should to of Health and Ment item 27 is marked rother traumatice		19a. Informant's Name/Relationship (STEVEN BROWNSTE			6927	DIANA R		ALTIMORE	, MD	or Town, State, 2 21209	
aftimore,	Page nent ant: II		20a. Method of Disposition 1	v)	State AI	NSHE E TZ CHA	sition (Name of matory of other pla MUNAH — LIM CONG.		Date /26/2008		LOCATION - City or	
Ra	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	Cittle	2			STERST	OWN ROAD	- PI	N & BROS KESVILLE	., INC. , MD 21208
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on e	ach line.		er the mode of dyi		,	ory arrest,	i	Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>		b	or as a consequence or a consequence or a consequen							
,	ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequ							
09/89	tificate be or g physicial as the buri	dical		_d								
.O. Box	w requires that the death certifichen signed by the attending the should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1☐Live b	come pf pregna irth 2 □ Fetal ant at time of de own	death 3	Ectopic pregn <i>a</i> nc Other (specify)	у		_	23d. Date of deli Month	very Day Year
Records, P	requires that een signed b nould be deta	by P	Part II. Other significant conditions of	ontributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part I.			use contribute to	the cause of death? obably 4 □Unknown
-	12 S 2	Completed							1 :	Was an autopsy performed?	prior to c	topsy findings available completion of cause of 2 ☐ No
0	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 27 No 27. Manner of Death	Hospital: 1 🔲 I		ER/Outpatien		er: 4 □ Nurs		Residence		city) Gilchnist
JIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Certification:	1 Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	(Mont	h, Day Year) of injury - At ho	Injury me, farm, stre	Wor	k? Yes 2∐No	28f. Location	on (Street a	jury occurred and Number or Ru	ral Route Number,
5	Fo the Hospital or within 24 hours afte Fo the Funeral Dir completely filled in I		29a. Certifier 1 Certifying Ph	ysician: To the	best of my know	wledge, death	n occurred at the ti	me, date and	place, and due to	the cause	(s) and manner as	stated.
	To the He within 24 To the Fu	Medical	(Check only one) 2 ☐ Medical Example 29b. Signature and title of certifier	and manr	asis of examinat ner stated.	tion and/or inv	vestigation, in my o		occurred at the t		and place, and due Date signed (Monti	
			30. Name and address of person who) completed cause	e of death (Item	23a) (Tyne		0183	20		1/25/08	
	Sta	20	31. Date filed (Month, Day, Year)	Ns.	طهر سنا egiştrar's Signat	rvaul		2109	3.			
	Registr		FEB 2 7	2008	Sperior	ANT A	good !					

3

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier





1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

12/365

29d. Date signed (Month, Day, Year)

2-25:08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		artment of H rtificate of L		d Mental Hy	giene Reg. No. (2000	05025		
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	_ U U O _Year	3. Time of Death		
	/Medic	al	ROBERT HAROLD C				4b. City, Town, or	Location of D	FEBRUAR		ounty of Deat			
6.0	Examin	er	Saint Joseph I						V5071	Baltimo				
<u> </u>	Funeral Director		217-03-3143	7. Ag	e (In yrs. la 87	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Bin Min. (Month, Da Feb 20	th ay, Year) 192	9. Birt Co 1 Mar	thplace (State or Foreign buntry) 'y land		
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
	Mary a-f sho	tor	Maryland Baltimore	County		T	owson					1 ∐Yes 2 No		
	or 28	Funeral Director	10e. Street and Number	1			10f. Zip Code			10g. Citize	en of What Co	ountry?		
	eath w	eral	1002 Kirkcolm Roa	12. Was Decedent I	Ever in U.S	3. 13.		.286	? (Specify Yes or No)- 14	USA 1. Race - Ame			
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygione. If Health and Mental Hygione. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:		1	lf Yes, specify Cuba 1 ☐ Yes 2 🔀 No	in, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		Black, White			
2-0	72 ho 'natur dical l	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	Ţ	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	working	16b. Kind	d of Business/	/Industry		
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retired Oprietor) -		Drv	Clean	in⊊		
d 2	Elementary/Secondary (0-12) To any depth of the party of						SPIZOCOZ	18. Mother's	Name (First, Middle					
ylar	ould by Menta arked atic ev	TOE	Robert G. Ca					Ma			nknown			
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty)						r Rural Route Numb	•				
	s 1 and f Heall item 2 other		Barbara A. Munson 20a. Method of Disposition		20b. Pla	ace of Dispo	Sition (Name of matory or other place	Koaq,	Towson, M		nd ZIZ			
im 0			1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	lemoval from State		en Moi	unt Crema	tory 2	/28/08	Balt	imore.	Marvland		
Balt	21. Signatul of Function Service aucom Martin D. Lawson						6500 York Road, Baltimore, Maryland 21212							
ĸ			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appropriate Cause (Final											
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			OMA					MONTHS		
	Examiner			Due to (or as	a consequ	ence on.								
1	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):								
٧	execute and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								
68760,	ificate be executed g physician and as the burial-transit	edical E		1										
Вох 68	E 00 66		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome			Ectopic pregnancy	,		23	Bd. Date of de Month	livery Day Year		
oʻ	the dea y the at ched fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of de	ath 5	Other (specify)				Worth	Day 16al		
4	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	by	Part II. Other significant conditions con	ntributing to death b	ut not resul	lting in the u	nderlying cause give	en in Part I.				o the cause of death?		
or Vital Records,	aw requir s been si 2 should l	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of		
E E		Som							perf 1□ Yes	ormed?	death?	s 2 No		
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	Death (Check only					
		ion: To	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry	28b. Time o	f 28c. Injur	4 LI NUTSII	ng Home 5 ☐ Res 28d. Describe			ecify)		
Division	I or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, et	ury - At hor c. (Specify	me, farm, str)	reet, factory, office	100 2	28f. Location City or To	(Street and wn, St a te)	Number or R	ural Route Number,		
_	Hospita 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Exami		f examinat									
	To the within 3	Me	29b. Signature and title of certifier	11.	/		29c. Licens	e number		29d. Date	signed (Mont	th, Day, Year)		
	1		Mull	"WA)				4827		4	14/0	+		
	17		30. Name and address of person who co				·	TUE	TOWSON.	MORV	LAND	21204		
	Sta		JAMES G. FRE I 31. Date filed (Month, Day, Year)	32. Registr			Scarles	A V lun #	1 2005 AA 2005 12 A 48	:::::::::\ <u>1</u>	tim t 27 79 8nd	2000 4% \$400 200 \$		
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

10802 HICKORY RIDGE RD

32. Registrar's Signature

COLUMBIA

MD 21044

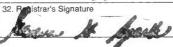
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** WILLIAM ALLEN DAVIS 4:47 a.™ 24, 2008 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Gilchrist Center 8. Date of Birth (Month, Day Year) 26 Aug. 19,1926 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1**√** M 2□ F Months Days Hours Maryland 216-20-5856 81 Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Towson Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 21204 U.S.A. 18 Dixie Drive death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give TATA 1 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cent of Health and Mental Hygiene.
Interfere I flew 27 is marked other than "natural", or iter ury or other traumatic event, the Medicial Examiner ury or other traumatic event, the Medicial Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White WW 11 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finanical Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eulallah Stewart Julian Bibb Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 18 Dixie Drive Towson, Maryland 21204 Mrs. Edith Davis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 2-28-08 Timonium, Maryland Dulaney Valley Mem. Cdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner premonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed MRSA burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Souther (Specify) WOSPICO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) D0051926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Gardan Charles of Baltman up MD 6565 Helen 21204

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Nadine C. Dixon 10:30 P. M February 23, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore N/A9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K F North Carolina 50 Director 219 70 1928 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at N/A Maryland Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Vine Street 21223 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 years Elementary/Secondary (0-12) Counselor Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Aldine Young Margaret Dixon 2 and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Evertte / sister 30 Colony Blvd. Wilmington, Delaware 19802 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 02/28/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. art1. Enter the diseate, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to him adiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATIC ENCEPHALOBATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an LIVER FAILUR 2 2 100 1∐ Yes Division or Vital To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | HOSPICE Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026327 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) CAMPFIRE, COLUMBIA, MD 21045

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 8876 2-27-08 vt. State of Maryland / Separtment of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3 2008 sarah /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Mercy City Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 231-28-4272 1 ☐ M 2 🖼 89 09.17.18 Director ira inia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Director MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in Baltimore National Rke 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Specify: Black þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Services aterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jary ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Rd. Balto. MD. 21229 4242 ackson ton eon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Balto. 2.2 em. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene 5131 Baltimure 21. Signature of Funeral Service Licensee Funeral Services for C. Vaus Balto MD 21229 Nect!) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart disease or condition resulting in death) -ongestive years /Medical Due to (or as a consequence of) Examiner Renal Conte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Day in the past 12 months? 1□ Yes 2☑ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. hours after death uneral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier LONGE Kinares

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State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linares

32. Registrar's Signature

Jerom ca L 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State amend #7&8 Per FH G877 3/12 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Day 27/1 mes 2 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year, 1920) 9. Birthplace (State or Foreign Country) OAK CREST VILLAGE Parkville If Under Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**∑**M 2□F 87 Director 29, 4921 Maryland 214-14-5978 Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore County Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? emit. Pages 1 and 2 should be filed within 72 hours after death w Cept riment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a ny njury or other traumatic event, the Medical Evaninations. 8832 Walther Boulevard 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White Specify: <u>و</u> 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Clinton Emich Julia Marie Drechsler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Clinton C. Emich (Brother) 7833 Ellenham Road, Ruxton, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Druid Ridge Cemetery 2/28/2008 Pikesville, Maryland 21. Signature of Funeral Service Vicenses 22 Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consuence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine The law requires that the death certificate be executed Due to (or as a consequence of) vísion ór Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death I Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury 28b Time of 27. Manner 28c. Injury at Work? 28d. Describe how injury occurred 1 atural
2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. Dicense number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 31. Date filed (Month, Day, Year) FEB 2 7 32. F State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb 20:08 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maryland Medical Center 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Nur 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 1 M 2 □ F none Feb 18, 2008 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☐ No MD Prince George's Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Philadelphia Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Stella Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) University of MD Med Ctr 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\\Other(Specify) in state 21 Signature of Euneral Sorvice Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore MD 21201 23a. Part1. Enter the discusse, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. ans Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of igoharamni (ra) a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown P se contribute to the cause of death? No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 2 No 2 □Other (Specify) 2 occurred Number or Rural Route Number

The law requires that the death certificate be executed and I-tran attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, ed by the a signed t as been si 2 should I has page certificate this After t Hospital or Attending death. within 24 hours after death

To the Funeral Director:,
completely filled in by the f

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Examiner

Physician/Medical

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Completed

Be ြို

Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

art Ii. Other significant condit	ions con	tributing to death but not res	ulting in the unde	erlying ca	use given in Part I.		Did tobacco us 1 ☐ Yes 2 ☐	
							Was an autopsy performed? Yes 2 ☐ No	
5. Was case referred to medica	al				26. Place of Dea	ath (Check o	only one)	Ì
examiner? 1 ☐ Yes 2 ☑ No	Н	lospital: 1 phpatient 2	ER/Outpatient	3 🗆 DO/	Other: 4 Nursing H	lome 5□	Residence 6	
Z [] Accident	igation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	3c. Injury at Work? 1 Yes 2 No	28d. Desc	cribe how injury	
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		28e. Place of injury - At he building, etc. (Special	ome, farm, stree fy)	t, factory,	office	28f. Locat City o	tion (Street and or Town, State)	Ī

(Check only ane) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

s Greene Street, as B110, Balfimore mb 21201

State

Date filed (Month, Day, Year) FEB 2 7 Registrar

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 45 aper doc 18876 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 15 PM Felsenberg 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death Randal istown 4c. County of Death **Examiner** HOSPIZE (1) more 8. Date of Birth (Month, Day, If Under 1 Year | If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Sex 1 M M 2 □ F **Funeral** Yrs. 10/01/1930 ΜD Director 212-30-4665 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8531 RAMORT DRIVE 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No KOREA If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 🗡 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN **JOSEPH FELSENBERG** MINNIE BUCKNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY ROSIAK / DAUGHTER 8531 RAMORT DRIVE, BALTIMORE, 20b. Place of Disposition (Name of AN Same er Kull NAH) or other place) AITZ CHAIM CONG. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 □ Cremation 3 □ Removal from State 02/25/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-transi Due to (or as a d nsequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate la 1 ☐ Yes 2 ☐ No 9 To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e NW Hospital Center Deasons

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

		-	For State Registrar	State of M	aryland		artment of H <i>rtificate of l</i>			giene Reg. No	111118	05833
			Decedent's Name (First, Middle, L.)	ast)					2. Date of Dea			3. Time of Death
	Physicia /Medic		Ma	rtha V. Fal	oig				FEB.	18	3 2008	7:20 P M
1	Examin		4a. Facility Name (If not institution, g			, amp		Location of Death		4c.	. County of Deat	
			BERLIN NURSING 5. Social Security Number 6.		je (In yrs. la			IN If Under 24 Hrs.	8. Date of Birt (Month, Da	th	WORCES 9. Birt	TER unplace (State or Foreign untry)
п	Funeral Director		212 10 4776	1□M 2∏F	93	Yrs.	Months Days	Hours Min.	(Month, Da) July 27	7, Year	914 Mar	yland
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Le	ocation					10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show r rust be notlined at	to	Delaware Suss	ex	Se	lbyvi	11e					1 ☐ Yes 2 ☑ No
	ith the Mi or 28a-f	Director	10e. Street and Number				10f. Zip Code			•	tizen of What Co	untry?
	ath wi	rai	31 East Stoney			1	199				U.S.A.	
920	or Ite	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	72 hours 'naturel', dical Ex	Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Dece (Give	dent's Usual Occup	ation during most of worki	ing	16b. K	(ind of Business/	Industry
121	within ene. then '	mp	Elementary/Secondary (0-12) 8th	College (1-4or	5+)		<i>bo nor usa ratirad</i> emaker	7)			Own Hom	e
d 2	a filed Il Hygi other vent, I	Be Co	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle,	Maiden	n Sumame)	
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Maryland 21215-0036	12 sho h and 7 Is m traum	3	19a. Informant's Name/Relationship Linda Riley /				ng Address <i>(Stre</i> et) ast Stone:	and Number or Rura			or Town, State, 2 Delawar	
	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is marked othe or other traumatic event,		20a. Method of Disposition		CO	ace of Disp	osition (Name of matory or other place	- !	Date		ocation - City or	
Ë.	Pages nent of ant: If if ury or c		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spe		Mea	dowri	dge Mem.	Park 02/2				
Baltimore,	permit. Pages Department of Important: If i any injury or 20008.		21. Signature of Funeral Service Lic	ensee	unk	/		ss of Facility Go: ie Highwa				e, P.A. land 21225
68760,	ircate be executed / Medical Examming sthe purial-transit sthe purial-transit states from the control of the co	edicai Examiner	23a. Pert1. Enter the disease or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as c. Due to (or as d.	s a conseque	ence of):	Cardet	ovascula	Disa	re		Onset and Death
P.O. Box 68	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	□Ectopic pregnancy □ Other (specify) _	,			23d. Date of dei Month	ivery Day Year
	uires that n signed b	by	Part II. Other significant condition	contributing to death	but not resu	Iting in the I	underlying cause giv	en in Part I.		obacco Yes 2		the cause of death?
Division of Vital Records,		Completed							24a. Was autor perfo		prior to death?	itopsy findings available completion of cause of 2 No
Vita	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	26. Place of Deat			- 70	
of	Physic rthis rat dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Da		P/Outpatie 28b. Time (of 28c. Injur	y at	me 5 Resi 28d. Describe		6 ☐Other (Spe ury occurred	cify)
ion	nding I ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investiga		ay Year)	Injury	Wor	k? Yes 2 □ No				
Divis	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of in	njury - At hor tc. (Specify)	me, farm, s	treet, factory, office		28f. Location (City or To	Street a wn, Stat	ind Number or Ri te)	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medicel Ex	Physicien: To the besient eminer: On the basis and manner s	of examinati	vledge, dea ion and/or i	th occurred at the tir nvestigation, in my c	me, date and place, pinion, death occur	and due to the red at the time,	cause(s	s) and manner as nd place, and due	s stated. to the cause(s)
)	To the within Complex complex	Me	29b. Signature and title of coaffler	me	ns	\supset	29c. Licens	9 876 9		29d. Da	ate signed (Mont	h, Day, Year)
6	0		30. Name and address of person with the Court of Porock	no completed cause of	death (Item	23a) (Type	oprint) of A	gleng 1	Faure	te	Telend,	De 1994
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 7	32 Regist	trar's Signat	ure	ade					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State	State of Ma	-	partment of H		lental Hy	giene	
			Registrar			ertificate of	Death		Reg. No.	18.05834
.00	Physici /Medio		1. Decedent's Name (First, Middle, La	th Mildred	Farrow			2. Date of Dea Month Februa:	Day Ye	3. Time_of Death 4:20 A.M
	Examir		4a. Facility Name (If not institution, give	· ·			Location of Death		4c. County of [
		₹e.	Caroline House			Dento			Caro	
Ü	Funeral Director		5. Social Security Number 6. S 215 14 4820	ex 7. Age □M 2kg F	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 19	y, Year)	Birthplace (State or Foreign Country) laryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Aaryla sho ed at	ō	Maryland Carol		Denton					1 □Yes 2★ No
	the N 28a-	rect	10e. Street and Number		Dencon	10f. Zip Code			10g. Citizen of Wha	
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980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mential Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		 Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 No 	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, \ Specify: \	American Indian, White, etc. White
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Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+	.)	ive kind of work done le. DO NOT use retired memaker	d)	9	Own	Home
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yla	Meni Meni arkec	2		Graves				Reinha		
	and 2 sh ealth and n 27 is rr		19a. Informant's Name/Relationship (Pamela Curry /			ailing Address <i>(Street</i> 14 Greenwoo			er, City or Town, Sta Maryland	. ,
re,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	i	Date	20c. Location - Cit	
Baltimore,	permit. Pages: Department of I Important: If ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y)		ill Cemete	ry 02/2			, Maryland
Bal	permit. Pa Departmen Important: any injury once.		21. Signature of Fundral Service Lice	aldr	idge.	22. Name and Addre	00.		eral Servi imore, Mai	ice, P.A. ryland 21225
,	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Al	the de	enter the mode of dyir	ng, such as cardiac	14	rrest,	Approximate Interval Between Onset and Death
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68760,	tificate be executed g physician and as the burial-transit	edical		d						
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n 0	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day					how injury occurred	House
Division	Attending r death. ector: After by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b		rv - Δt home farm	M 1 □	Yes 2 □ No	29f Location (Street and Number	or Rural Route Number,
Div	after after Direction by	ertif	4 ☐ Homicide determined	building, etc.	(Specify)	, street, ractory, office		City or To		or nurar noute Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one)	nysician: To the best o miner: On the basis of and manner stat	examination and/o	eath occurred at the tier investigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	Fo the Within Fo the Comple	Me	29b. Signature and title of certifier	1//2		29c. Licens	e number		29d. Date signed (F	Month, Day, Year)
			1 = 7	SHI	MI	2 Do	0475	34	2/2	6/08
Ír	8		30. Name and address of person who			pe, Print)	•			
T.	Sta	te.	Wafik Zaki MD. 31. Date filed (Month, Day, Year)	920 Marke	r's Signature		, Marylar	ia 21629	3	
	Registi			108 Sales	A A	parte				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #26, perVerbal C876, 2/27/08 Gertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 11:03AM February Thomas J. Greenwald 26,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kernan Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 202-28-8193 69 Yrs. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Monocacy Circle United States Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 XYes 2 No Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: Era 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Public Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Warren Greenwald Catherine Marie Mason ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Anne Greenwald, Wife 32 Monocacy Circle, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fernwood Cemetery 03/01/2008 Royersford, PA 4 ☐ Donation 5 ☐ Øther (Specify) M01113 22. Name and Address of Facility Campbell. Ennis, Klotsbach FH, Inc Service Licensee A 19460 Approximate Interval Between Onset and Death Immed 5day diseas resultir

permit. Pages 1 and 2 should be filled. Department of Heelth and Mantal Horitoportant: if item 27 is more only injury or other. Physician /Medical Examiner

Funeral

Director

r than "naturel", or iteme 23a or 28a-f eho the Medical Examinar must be notified at

e filed within 72 hours after if Hygiane. other than "naturel", or Ite

Baltimore, Maryland 21215-0036

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burial-transit use as the ned by the atten within 24 hours aftar deeth. To the Funeral Director: A completely filled in by the fu

or Attending Physicien: The law requires that the daath certificate be executed Division of Vital Records, P.O. Box 68760,

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1 Som		610 Main Stree	t, Phoenixville, PA	
23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death. Do not only one cause on each line.	not enter the mode of dying, such a	is cardiac or respiratory arrest,	م ا
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		Fracture	
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or as a consequence	of):	19 willett N	2
that initiated events resulting in death) Last	c. Due to (or as a consequence	of): CERTI	OVED BY SMEDICAL STRUM	
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_	23d. Da	ate of delivery
in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		onth D

Sequer if any, I cause. Cause that init resultin Examiner Be Completed by Physician/Medical Part II. Other significant condition 25. Was case referred to medical 27. Manner of Death Certification: Medicai

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

examiner? Yes 2□ No

5 Pending

investigation 6 Could not be determined

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)
s contributing to death but not resulting i	n the underlying cause given in Part

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown

Month

	24a. Was an autopsy performed?
26. Place of Death	(Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2[X No 1 Yes

Day

Year

Ho	spital: 1 XInpatient	2 🗆 ER/0	utpatien	3 🗆 🛭	Other: 4	☐ Nursing H	lome 5	(Pesidence	6 ☐Other (Specify)	
Ī	28a. Date of Injury (Month, Day Y	'ear) 28b.	Time of		28c. Injury at Work?			escribe how inju	ury occurred	
	February 22,2	008 10 3	OA	М	1 ☐ Yes	2.0 No	7	fall		
	28e. Place of Injury building, etc. (- At home, fa	arm, stre	et, facto	ry, office		28f. Lo	cation (Street a	and Number or Rural Ro	A Crack
		H.	Om	0					Maryland 21	787

	Home	lane	TOWN	Mary	19 NG 21	181
29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and due to ation, in my opinion, death occurred at the	the cause(ime, date ar	s) and ma nd place, a	nner as stated and due to the	cause(s)
25 C:	d sixty of analytics	00-1	104.0		1 (1.4 + t - D	141

29b. Signature and title of certifier		29c. License numbe
I him web tallo NI)	Attending	01866

29d. Date signed (Month, Day, Year)

6/ Name and address of person who completed cause of death (Item 23a) (Type, Print) Hill CT. Lutherville, Maryland 21093 Trumble MD is Militello

State Registrar 31. Date filed (Month, Day, Year) FEB 2 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:51 A. Andrew M. Garreis February 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 129 Severn Wav Arnold <u>Anne Arundel</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1X□ M 2□ F 219 38 0724 Director 68 08/04/1939 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Exercitive must be notified at 1 ☐ Yes 2√ No Director Maryland Anne Arundel Arnold 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 129 Severn Way 21012 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Policy Analyst U.S. Government vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil iment of Health and Mental H tant: If item 27 Is marked otl John H. Garreis Helen Kalivoda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Garreis / wife 129 Severn Way Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. Bayview Crematory 02/21/2008 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura o Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Part1. Enter the dise so or shock, or heart failure. Lis omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 MONTHS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Cher (specify) 4☐Pregnant at time of death be detached 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Anknown 3 Probably 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2□ No 1 Yes Yes 2 or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 Yes Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of fnjury (Month, Day Year) Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? Director: After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours Certifying Physicien: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who gompleted cause of death (ftem 23a) (Type, Print) 4710 KICHAIRD E INGTON FISHEM 32. Registrar's Sh State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert George		State of Maryland / E - For State Registrar		rtment of tificate of			Mental	F	Reg. No. 20	008 0583	
Physicia Medical Examin		Decedent's Name (First, Middle,Last) Robert Geo	rge				-	2. Date of De Month February	Day Year	3. Time of Death 1403 hrs	
16 c		4a. Facility Name (if not institution, give street and number)	1 ge		b. City, To	own, or Lo	ocation of D		4c. County of D		
	Ц	5309 Brookwood Road			Brookl				Anne Aruno		
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 214 54 1792 1								. Birthplace (State or preign CountryMaryland	
	}	Usual Residence of Decedent								Country/1a1 y 1ailu	
v any	1	10a. State 10b. County 10		Town or Location	on		-			10d. Inside City Limits	
Aaryland 28a-f show 1 at once,	ġ	Maryland Anne Arundel	В	cooklyn						1 Yes 2 No	
te Mar or 28a	Director	10e. Street and Number 5309 Brookwood Road			10f. Zip	1225			10g. Citizen of What C		
with the ns 23a se noti		11. Mantal Status 12. Was Decedent Eve	er in U.		Deceder	nt of Hispa		(Specify Yes or N	lo- 14. Race - A	merican Indian, Black,	
death or iten	Funeral	1 Never Married 2 Married 1 Armed Forces? 1 Yes 2 X No						uerto Rican, etc.)	White, et		
irs after ural",	হ	Widowed 4 X Divorced If Yes, Give Year or Dates: Decedent's Education (Specify only highest grade complete)	eted)	16a. Decedent		X No		d of work done		Specify: White b. Kind of Business/Industry	
72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,,,,,	during mo	st of work	king life. [OO NOT use				
within jene.	팂	12th			Baseball Player				Pro Spo	rts	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than event, the Medica	ညို မြ	17. Father's Name (First, Middle, Last) (not available)	G	eorge		18		wame(First, Middle Ouise Bor	, Maiden Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing			and Numbe	r or Rural Route Nu	umber, City or Town, S		
MD and 2 sho salth and 2 sho sem 27 is raumati		Gerald Duncan / friend 20a. Method of Disposition	205 [130 E			venue	Brook	Lyn, Maryla		
Baltimore, permit. Pages I an Department of Hea Important: If itee injury or other tr		1 Burial 2 X Cremation 3 Removal from State	(crematory or oth	er place)		.	2/27/2008		ore, Maryland	
altim nit. Pa nartmer nortan	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Da	yview Ci					neral Serv		
E Pariti				400)1 R:	itchi	e Hig	hway Bai	ltimore, M	aryland 21225	
Physician /Medical		23a Part I. The fine disease, or complications that caused the failure. List only one calls e on each line.				of dying, s	uch as card	iac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death	
vaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Ca			ease					Death	
	٦	Sequentially list conditions, b.		·					···		
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ence o	f):							
led nsit	Examiner	events resulting in death) Last	f):								
50, te be executed tysician and e burial - transit	ledical	UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Med	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	of preg	nancy					23d. Date of de		
Box 6876 ne death certificate the attending phy ned for use as the least	Physician/M	past 12 months? 1 Live birth 4 Pregnant at tim	ne of de	oth	al death ner (Spec	3 ∟ cifv)	Ectopic pr	regnancy	Month	Day Year	
BO)	hysi	1 Yes 2 No 9 Unknown g Unknown						[00.00			
P.O.	ব	Part II. Other significant conditions contributing to death be Chronic alcohol abuse	ut not re	esulting in the u	nderlying	cause giv	ven in Part I			te to the cause of death? Probably 4 V Unknown	
ords, P	ompleted							24a. Wa		re autopsy findings available	
of Vital Records, ag Physician: The law requin fler this certificate has been si meral director, page 2 should b	팂							per	formed? dea	or to completion of cause of other inth? Yes 2 No	
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical			2			neck only one)			
F Vit	힏	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury		ER/Outpatient				lursing Home 5	Residence 6 🗸		
ion of teuding Pt eath. tor: After the funeral	<u>ë</u>	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	ijury 12		at Work?	1	e how injury occurred		
Division tal or Atteudi rs after death. al Director: /	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	y - At h	ome, farm, stree	t, factory,	office bu	ilding, etc.			or Rural Route Number, City	
Djy spital o tours af neral D	Certification:	4 Homicide determined (Specify)						or Town	, State)		
Divis To the Hospital or A within 24 hours after To the Funeral Directory filled in b	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my king one) 2 Medical Examiner:On the basis of examiner									
To t Com	and manner stated. 29b. Signature and title of certifier							(Month, Day, Year)			
		Paret Korthall, MA				O.C.N	1.E.		February 20,	2008	
118		30. Name and address of person who completed cause of deal	-		l Da	Chro-1	Daltima	ro MD 24224	l,		
4	100	Pamela E. Southall, MD Assistant Medica 31. Date filed (Month, Day, Year) 32 Registrar's	_	e	Penn	Street,	Daitimo	re, MD 21201			
Sta Registr	Œ	31. Date filed (Month, Day Year) FFR 2 7 2008 32 Registrar's	J. gira	a property of	No.						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 8876 2-27-08 vt. State of Maryland P Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Year **Physician** Day Harmon tilda /Medical Famility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore inai If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 09.02. Social Security Number Birthplace (State or Foreign Country) **Funeral** 216-32-1596 Days Months 1 □ M 2 🗙 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglens. Department of Health and Mental Hyglens "Inaurust", or litems 23a or 28a-f show Important: If item 27 is markled there than "naturust", or litems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at timore 1 es 2 No MDDirector 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country 21209 lamarina Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retind) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tersonnel Yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Dalto. Harmon mo 2/2/7 Konnie 1 on Place of Disposition (Name of demetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, 4 Donation 5 Other (Specify) 21. Sign, tule of Funeral Service License Nat'l Pilce 5151 Balto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician reak. /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes al or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 2 1 No 1 TYes 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ∏Yes 2 ∏No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Road sure 204 Catoprille

State

Registrar

new

516 N. Rolling

30. Name, and address of person who completed cause of death (Item 237 (Type, Print)

MD

32. Registrar's Signature

Ambro

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Edward J. Harig 3;45 February 2008 Α. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Glen Burnie Health & Rehab. Glen Burnie 8. Date of Birth (Month, Day, Year) May 31, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min 1X M 2 □ F 212 09 2412 89 Maryland 1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 102 Cloverhill Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Tayes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 🕱 Married White 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brakeman Railroad 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Harig Sara Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1679 Tarleton Way Crofton, Maryland 21114 Susan Bents / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 02/25/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur nuneral Savice Lansee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Demente Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be fill timent of Health and Mental H lant: If item 27 is marked ott

or other

Department of important: If any injury or once.

burial-transit attending physician for use as the buria been signed by should be detach page 2 should

the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

certificate has After 1 death.

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled State

Examine Physician/Medical ۾ Completed Be 2 in by the funeral Certification:

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

perform 26. Place of Death (Check only one)

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Road 103 balavanar

31. Date filed (Month, Day, Year)

32. Registrar's Signature pourar's Sigi

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 00 2008 bruce 25 /Medical or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner Salt more Maryland Iniversity 5 If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Numbel 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreigr Country) **Funeral** Days Months 212-28-0323 1 □ M 2 🗙 F 84 Director May 10, 1923 Pitt Co. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No NC Pitt Greenville Directo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 27858 USA 760 Circle Drive Funeral 14. Race - American-Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) domestic homemaker 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rowena Daniels ဥ John Langley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once. Tammy Salisbury 760 Circle Drive; Greenville, NC 27858 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Homestead Memorial Gardens 03/01/2008 4 ☐ Donation 5 ☐ Other (Specify) Greenville, NC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final Physician MONIC 055 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy lo. Month Year Day 5 ☐ Other (specify) been signed by the a should be detached t 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? certificate 2 No Physiclan: 25. Was case referred to medical examiner?
1 ☐ es 2 ☐ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) To the Hospital or Attending 1 Natural 5 Pending investigation 1 TYes 2 No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 🔍 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

	1	For State Registrar	State of Ma	ryland /		rtment of F		Mental H			
. Physician		1. Decedent's Name (First, Middle, Las James Melvin Heno	,				- Journ	2. Date of D Month	[Day 20 Year	0 / 12 .0 14
/Medica Examine	400	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, o	r Location of Dea Baltim			4c. County of De	1. 131
Funeral Director		5. Social Security Number 6. S 212-46-5701		(In yrs. last	<i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of B	irth Day, Yea	9. B	irthplace (State or Foreign Country) MD
Maryland -f show fled at		Usual Residence of Decedent 10a. State 10b. County MD		10c. City, To	own or Loc	eation Balti	more				10d. Inside City Limits
h with the Mar 3a or 28a-f sh st be notified		10e. Street and Number 1400 Poplar Grove St	reet			10f. Zip Code	21216		10g.	Citizen of What C USA	Country?
"natural", or items 23a or 28a-f show dical Examiner must be notified at lead of the European Director	2	11. Marital Status †☑Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Et Armed Forces? 1x□XYes 2 □ No If Yes, Give Year or Dates:		11	Vas Decedent of H Yes, specify Cuba ☐ Yes 2KM\o	lispanic Origin? (an, Mexican, Pue Specify:	(Specity Yes or Nerto Rican, etc.)	10-	14. Race - Am Black, Wr African Specify:	nite, etc.
permit. Pages 1 and 2 should be filed within 72 hot Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natur: any injury or other traumatic event, the Medical once.	- Increase	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+		6a. Deced (Give life. D	ent's Usual Occup kind of work done OO NOT use retired	eation during most of w d)	rorking	16b.	. Kind of Busines	s/Industry
led will lygien rt, the	5	12				custodian					City Schools
Duid be fill Mental H arked ott attic even	3	17. Father's Name (First, Middle, Last) Alexander	: Henderson					ame (First, Middi Ethel Lee		,	
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Tethel Henderson / Mo	**		1400	g Address (Street Poplar Gro		; Baltimor	e, M	D 21216	
ages 1 int of H t; if iten		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □		ceme	etery, cren	sition (Name of natory or other place	i .	Date 21 /2009		Location - City o	
nit. Pa artme ortan injury	ŀ	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Garri		rest Vet.		21/2008 Walie Fur		.ngs Mills .Home, P.A	, Maryland
permii Depar Impor any ir		Junila ()	Oues)			638 N. Gil		-			
Physician		23a. Part1. Enter the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused to one cause on each line	he death. D	o not ente	er the mode of dyin	ng, such as cardi	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions,	b. Due to (or as a	enter	rsia	`	,	7			years
icate be executed physician and sthe burial-transit	1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	·							
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the control of the physician/Median		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of d Month	lelivery Day Year
res the ignerigate be d	5	Part II. Other significant conditions of	ontributing to death but	not resulting	g in the un	derlying cause giv	en in Part I.				to the cause of death? Probably 4 Donknown
Ø Ω .									opsy form <u>ed</u>	prior to death	
/sician: Th)	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		O. da adia a	t 3 DOA Oth		eath (Check only			
Attending Physician: r death. ector: After this certification; by the funeral director.	· -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28	b. Time of Injury	28c. Injur Wor	4 🗆 Nursing			e 6 □Other (Sp njury occurred	оеспу)
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Modical Certification: To Be		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of injur building, etc.	y - At home, (Specify)	farm, stre	eet, factory, office		28f. Location City or T	(Street	t and Number or tate)	Rural Route Number,
o the Hospit ithin 24 hours o the Funera ompletely fille		29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exan	ysician: To the best of niner: On the basis of and manner state	examination	ige, death and/or inv	occurred at the til restigation, in my o	me, date and pla ppinion, death oc	ice, and due to the	e cause e, date	e(s) and manner and place, and d	as stated. lue to the cause(s)
Tot Tot COM		29b. Signature and title of certifier	BK	lu	/	29c. Licens		00	29d.	Date signed (Mo	20, 2008
3		30. Name and ddress of person who of	completed cause of dea	orth (Item 23a	a) (Type, 1	orint) ne Strae	+ Balt	imore M	lary	gland	20, 2008
State Registrar		31. Date filed (Month, Day, Year) FEB 2 7	32. Registrar	's Signature	k A	hour					
HMH 17 Rev 1/200	1	-	-	-	ORI	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Sophie Jachimski February 26, 11:50 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1406 Kent Road Baltimore Essex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/20/1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Maryland 216-07-9449 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show la or 28a-f show t be notified at 1 ☐Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1406 Kent Road 21221 U.S.A. "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francizek Gryalik Eva Horuzeu ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1406 Kent Road, Essex, Maryland 21221 Betty L. Pannebaker- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 02/29/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Europia Bervice Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final dise y e or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 38 aftending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the sidetached i 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 200 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) nours after death.

neral Director: After this ce
filled in by the funeral direc Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely

Registrar

State

29b. Signature and title of certifier

IHAMMAD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

4920 CAM

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEB **Physician** 2008 1:45 A M BUD JUSTICE JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BELAIR HEALTH + RE-HAB BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 📉 M 2 🗆 F Hours 407-30-8125 81 Director July 6, 1926 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show 10b. County "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Interest 27 is marked other than "natural", or items 23a or rans 1 be 1 and 3641 G Woodsdale Road 21009 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Boiler Plant Supervisor</u> U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (nmn) Justice Geneva (nmn) Charles Bud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline B. Justice / Wife 3641_Woodsdale Road, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Kurial 2 Cremation 4 □ Donation 5 □ Other (Specify) Air Memorial Grdn 2-27-08 Bel Air, Maryland 21. Highayure of File 1/5 Name and Address of Facility.
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part. Enter the disease or complications that caused the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician 70Ca isease or condition resulting in death) /Medical Due to (or as x con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably ↓ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy certificate l 1∐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lightedical Examing on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29c. License number 29b. Signature and til 30/ erson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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Year)

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2008

31. Date filed (Month, Day,

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32. Registrar's Signature

			For State Registrar	State of	f Maryland	/ Dep		f Health a		ental Hygi	_	08	05845
	Physic	an	1. Decedent's Name (First, Midd	1	474				2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medi			nore	Kelly					Feb :	22 2	208	10:50 AM
	Examir	ner	4a. Facility Name (If not institution	-				n, or Location o	of Death		4c. County		C
- 1 -		~	8832 Walther 5. Social Security Number		7. Age (In yrs. las	t hirthday		imore	24 Hrs. 8	B. Date of Birth	Balti		County
3	Funeral Director		220-07-3940	1 M 2 F	89	Yrs.	Months Da	ys Hours	Min.	(Month, Day,	Year) 1918		place (State or Foreign etry)
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	irylan show		10a. State 10b. County	/	10c. City,	Town or Lo	ocation					1	0d. Inside City Limits 1 ☐ Yes 2 No
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	with the	Dir	10e. Street and Number 8832 Walther	Dlerd			10f. Zip Cod			10	g. Citizen of W		ntry?
	eath is 23	Funeral	11. Marital Status		edent Ever in U.S.	13		21234	igin? (Speci	ify Ves or No.		SA - Americ	an Indian,
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2-0	J within 72 hours after death with the Marylan jiene. r than "natural", or items 23a or 28a-f show fihe Medical Examiner must be notified at	Completed	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual Oc	cupation one during mos	t of working	1	6b. Kind of Bu	siness/In	dustry
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	12 je g		Richard B. Kel	lly (Son)	6427	Blenhei	im Road	. Bal	timore.	Marvla	and 2	21212
re,	a: 0		20a. Method of Disposition		20b. Pla		osition (Name of matory or other		Da		Oc. Location -		
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Sign with of Furneral Salvice	Liver see auro	7	1	2 Name and Ad 11 TCHF1 T	dress of Facilit	FELD I	FUNERAL.	HOME. I	NC.	
	<u>20 = 90</u>			Lawson		16	ITTCHELL 500 Yor	k Road	, Bal	timore,	Maryla	nd 2	
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or Vital Records,	Physician; Th this certificate ral director, pag	Be (25. Was case referred to medica examiner?						of Death (Check only one	;)		
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	ding I. After fune	ioi	27. Manner of Death 1 Natural 5 □ Pendi	iig '	of Injury th, Day Year)	8b. Time o Injury	1	njury at Work? 1 □ Yes 2 □		3d. Describe how	w injury occurre	ed	
Division	Attending r death. ector; After by the funer	icat	3 Suicide 6 Could		of injury - At hom	e. farm. st				of Location (Str	eet and Numbe	er or Rus	al Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determ		ing, etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,			City or Town,	State)	77 07 11070	
	Hospital 4 hours a Funeral tely filled	alC	29a. Certifier 1 Certifyi	ing Physician: To the	best of my knowl	edge, dea	th occurred at th	ne time, date ar	nd place, ar	nd due to the ca	use(s) and ma	nner as s	tated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical	(Check only 2 Medica one)	I Examiner: On the band man	asis of examination ner stated.	n and/or ir	nvestigation, in r	ny opinion, dea	ath occurre	d at the time, da	ate and place, a	and due to	o the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certific	er			_	ense number		29	d. Date signed		
			1 gu				_ L	6178	35		2/2	2/0	8
	12		30. Name and address of person					0 1 11					
	Sta	ate.	31. Date filed (Month, Day, Year	n /10 83 32. F	800 Lb. Registrar's Signatu	. Ither	· Dlud;	rarkville	e, MD	21234	1		
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death with the Maryland Show rai", or items 2 Examiner mu Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 3altimore, Maryland 21215-0036

Physician /Medical

Examiner the burial-tran Division or Vital Records, P.O. Box 68760 attending physician use as the s been signed by the should be detached page 2 the Hospital or Attending Physician;

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month STANLEY WAYNE KEENEY, SR. FEB. 26, 2008 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLL HOSPICE DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-74-8475 52 Director 1/26/1956 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director CARROLL MD UNION BRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1728 BAUST CHURCH RD. 21791 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1974 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced 1978 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 PROJECT MANAGER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KENNETH MARTIN KEENEY SHIRLEY BELT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRIE C. KEENEY -WIFE 1728 BAUST CHURCH RD., UNION BRIDGE, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department important: If ALL COUNTY CREMATION 2/28/08 SYKESVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Inter it e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the rt failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mon nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 KOther (SpecifyHOSPICE 1 🔲 Yes 21 No ۵ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartiner (Type, Print) 5+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 **Physician** DSCOMB tebruan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tended c Social Security Number **Funeral** Months Hours 1 X M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner manages. 10a. State 10c. City, Town or Location 10b. County Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Sanitation boce.r 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (Wite) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 pscomb me GETITUDE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Home, P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph L. Russ 2222 W. North neral Ho e. Balto Ave. 23a. P. ff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ork, or hear vailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner ardiomyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ronar The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed

4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ∐ Yes 2 No 1□ Yes 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29b. Signature and title of certifier

TA 17D

29d. Date signed (Month, Day, Year) 2008

Month

Day

Year

2008

9:00

9/ Birthplace (State or Foreign Country)

American Indian

1ack

Black, White, etc.

10d. Inside City Limits 1 Yes 2 □ No

Approximate Interval Between Onset and Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(To vac E, Wicks MD, 3900) Loch Raven Boulevard, Battimore

State Registrar

Be

Certification: To

31. Date filed (Month, Day, Year)

To the Hospital or Attending Physician:

Director:

within 24

g

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0155 AM LUSTED, MD KEITH 02 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY BALTIMORE MARYLAND MARYLAND OF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1፟፟፟∭M 2□F 81 373-32-7681 Apr 28,1926 Director Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6504 Crestwood Road 21239 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7 Health and Mental Hygiene. om 27 is marked other than "n ther traumatic event, the Medi College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Lusted Maude Browning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trau Mr. Scott Lusted (Son) 1436 N.E. Paropa Court, Gresham, Oregon 97030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 2/25/2008 | Baltimore, Maryland 21. Signatury (Furral Service) ee

Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERALHOME, INC.
6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MULTI SYSTEM ORGAN FAILURE 3 Months 13 days /Medical Due to (or as a consequence of): Examiner NECROTIZING FASCITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or do a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ failure, Diabetes, Hypertension 1 Tes 2∏No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 1 res 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760, certificate be P.O. | Division or Vital Records,

filed within 72 hours after death

Pages 1

Baltimore, Maryland 21215-0036

inding physician and use as the burial-tran atten for u ed by the a detached f page 2 s To the Hospital or Attending

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

30. Name and address of person 31. Date filed (Month, Day, Year)

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

MAYUR

NARAYAN

ho completed cause of death (Item 23a) (Type, Print)

and manner stated.

22 SOUTH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

18230

GREENE STREET (Z120)

29d. Date signed (Month, Day, Year)

BALTIMORE

21

2008

02



Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Albert H. Laumann February 15 2008 5:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 109 - 12th Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 30, 19 **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F 93 213 09 6041 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Marvland Anne Arundel Baltimore 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 - 12th Avenue 21225 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∑ Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Barber Shop 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If teen 27 is marked othe any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Laumann 2 Minnie Dontell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8314 Fairwood Drive Patricia Dilaimy / Daughter Pasadena, Marvland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem, Park 02/19/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, upon shock, or heart failure. 4001 Ritchie Highway Baltimore, Maryland 21225 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and bunal-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Malnutrition 2N☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 🖄 Natural 5 ☐ Pending investigation Hospital or Attendil 24 hours after death. Funeral Director: A etely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital c within 24 hours aft To the Funeral D 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12729 02/26/2008 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 4710 Kennington Avenue Dr. Rifat Abousy Baltimore, Maryland 21226 31. Date filed (Month, Day, Year) 32. Register's Signature FEB 2 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Month ELSIE IRENE LEIZEAR 25, 2008 FEBRUARY 1:01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 □ M 2X F 212-20-1265 90 Apr. 15, 1917 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 2 □ No Maryland | Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2009 Mountain Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ➡Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Filemore Day Bina V. Wilcox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice M. Sexton / Daughter 1404 Brierwood Ct., Joppa, Maryland 21085 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 2-28-08 Bel Air, Maryland 21. Signature of funeral Service Licensee 22. Name and Address of Facility. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part I. Ent Ir the disease, or complications I at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) ISCHEMIC CATEDIOM YOPATHY Due to (or as a consequence of): CARDINVASCULAR RTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide

Physician /Medical Examiner Examine law requires that the death certificate be executed

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Department of Heam mportant: If Item

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Box 68760.

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Physician

/Medical

Examiner

Funeral

Director

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Funeral

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certificate • Hospital or Attending Physicien: 24 hours after death. • Funeral Director: After this certifica

Physician/Medical

Completed by Be 70 Certification:

Medical

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within 2.

Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

MYBhyankar YANKAR

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 25027

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INORTH AVE BELACE MD 2014 32. Logistrar's Signatur

FEBRUARY 15 2 008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22,2008 Year Mary Jean Lang February 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9307 Sea Point Road Sparrows Point Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F 219-26-3261 Director 69 March 30, 1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore Maryland Middle River Director 1 ∏Yes 2 TXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3512 Wheelhouse Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Cafeteria Manager K-Mart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James P. O'Neill Sr. Caroline Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Mocere Daughter 30595 Gordy Mill Road, DelMar, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 27, 2008 Oak Lawn Cemetery 4 Donation 5 Other (Specify) ign ure of Fun al Service License Connelly Funeral Home Of Dundalk, P.A. any 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death on other the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Urothelial ~12 months cancor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate ner Due to (or as a consequence of) Cause (Disease or injury Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 □ N6 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Position of Hospital: 1 ☐ Inpatient 1 Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, peen has e 2 certificate Hospital or Attending Physician: : After this certification in the funeral director, I within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. To the I

that the death certificate be executed

P.O. Box 68760,

and

physician

signed by the a d be detached f

the as attending p

within 72 hours after

filed

and Mental Hygiene.

permit. Pages 1 and 2:
Department of Health a

5

Baltimore, Maryland 21215-0036

State Registrar

1. Browner 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4940 Eastern Avenue

MD

ORIGINAL

AIII

D0058893

29c. License number

Ra Himore, MD 21224

29d. Date signed (Month, Day, Year)

February

2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **JOSEPH** LIEBERMAN FEBRUARY 5:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/09/1912 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 143-26-7290 95 POLAND Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits MONTGOMERY 1 ☐ Yes 2 🔀 No MD CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 WILLARD AVENUE 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER OPERATOR RETAIL LINGERIE STORES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LIEBERMAN UNOBTAINABLE MAYER UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) CYLA WIENER / DAUGHTER 11205 SPUR WHEEL LANE POTOMAC, MD 20854 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date CONGREGATION PEOPLE OF TRUTH 1 ☐ Burial 2 ☐ Cremation 3 🗓 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2008 TRENTON. 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): CONGESTIVE HEART FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence or) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division or Vital

Salack

Lieberman, Joseph

use as the burial-trar attending physician the page 2 should has

Physician/Medical

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Completed

Be

P

Certification:

Medical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

signed by the certificate funeral director, After this

To the Hospital or Attending after death Director: , 24 hours a e Funeral I

To the

State Registrar

6 Could not be determined

29c. License number D0063195

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 02/26/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN WILKS,

M.D.

8600 OLD GEORGETOWN ROAD,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

BETHESDA, MD 20814

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00 AM larine 09 08 onn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel 1735 tragarn tanover Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 1 2 M 2 □ F Months Days Hours 216168491 Director 9-07. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director tanover trundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21076 tragarn Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Yes, Give 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates "natural" f Health and Mental Hygiene.
Item 27 Is marked other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maineer and Father's Name (First, Middle, Last) Be ISCO larine rank ၉ 19a. Informant's Name/Relationship (Type. Print) (WHE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanover, MD. 21076 or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2.27.08 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Preene Funeral 21. Signature of Funeral Service License Services Balto. MD. 21229 5151 Battinure Nat'l Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy performed After this certificate 2□ No 1□ Yes 2☑ No the Hospitallor Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural fer dea... a) Director Affr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 29a. Certifier Castertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) lame and address of person who completed cause of death (He in 23-111 ype, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #24a,26,29d, perMD, g876, 2/27/@ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 051 **Physician** 21, 2008 ebru ary /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Richie NA MHIMORE HOSPICE If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign /Country) (In yrs. last birthday **Funeral** 1 ☐ M 2 🔼 F Hours Min. Yrs Director Max IRainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 No Director MARYLAND HIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with USA Ave. 5206 Greenwich Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: HMERICAN rican Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kin of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Domestic OWN. Home 17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a1,229 : If Item 27 Is laylor-Aue SAHIMORE, MARYlAnd DANdRA Greenwich 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 27,2008 BAItIMORE Department Important: If any injury o ESTERN 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
NAMEY M. WALLACE FUNERAL SERVICES
3405 W. FRANKIN STREET BALTIMORE MARYLAND 3/229 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death **Physician** -5march /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran and Due to (or as a consequence of): 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has N autopsy page perform certificate 2 **2** No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NATHAN 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient Director: After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. 29b. Signature of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 177-(50 TTSCH M)

State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d, per 10, e877 3/7/08 TT Department of Health and Mental Hygiene 1- State Registrar Amend 19a, perInf, C876, 2/29/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Molaughlin 8:13A M Patricia February 2008 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Harbor Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗹 F 215 76 3904 Director 45 08/05/1962 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location a or 28a-f show be notified at 10b. County 10d. Inside City Limits N/A 1 Yes 2 No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3520 Horton Avenue "natural", or items 23a edical Examiner must b 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 21/2 No Specify: White Completed by 3 ☐ Widowed 4 🕱 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert J. McLaughlin Jr. Irene McLaughlin ပ္ 19a. Informant's Name/Relationship (Type. Print)
Carla Loury / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 Horton Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Cedar Hill Cemetery 02/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility} Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hepitins C /Medical Due to (or as a consequence of) **Examiner** Resistant Staphyloroccus Aureus Premonia Methicilin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner End Stage The law requires that the death certificate be executed Liver disease the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/21/09 2008 SBONL Doctor Res 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sairah Bashir 3001 South Hanover Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State marke

Registrar

			Please	State of Maryland / Dep			_		
			For State Registrar	-	ertificate of Death	, ,	ea. No 2008 05856		
Į.		N.	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of						
В	Physicia /Medic		Lydia Anne Minit		Februar				
	Examin	er	4a. Facility Name (If not institution, give	4b. City, Town, or Location of	Death	4c. County of Death			
			Stella Maris Hosp 5. Social Security Number 6. Se		Timonium If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign		
ы	Funeral Director			□ M 28 F 76 Yrs.	Months Days Hours	Min. (Month, Day, Mar. 3,			
	D		Usual Residence of Decedent			1332 (0)			
	show	٦	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1 □ Yes 2√□ No		
	the M	recto	Maryland Harfo 10e. Street and Number	ord Be	l Air 10f. Zip Code	1	Og. Citizen of What Country?		
	3a or	io le	1911 Blair Cour	უ-	21015		USA		
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.		
98	after or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 21☐ No If Yes, Give	1 ☐ Yes 2 🗓 No Specify:		Specify:		
8	hours tural"	q pe	3€ Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	edent's Usual Occupation		White 16b. Kind of Business/Industry		
15	n "na n "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	re kind of work done during most DO NOT use retired)	of working	,		
21215-0036	be flied within 72 hours after death with the Maryland ntal Hygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/decondary (0-12)	4	Owner / Opera		Artist		
	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle, I	,		
<u></u>	should and Mer s marke	To	Arthur Thomas App		ling Address (Street and Number	na Marie Wol			
Maryland			19a. Informant's Name/Relationship (7 Karen E. Patrick		22 Moonshadow Ro				
ē,	ges 1 and 2 t of Health If Item 27 I or other tra		20a. Method of Disposition	20b. Place of Dis			20c. Location - City or Town, State		
Baltimore,	permit. Pages: Department of H Important: If Ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Service Corp	2-27-08	Towson, Maryland		
Salti	permit. Departr Importa any inju		21. Signature of Fundal Service Licen	30/	22. Name and Address of Facility McComas Funera				
	90 E # 9				50 W. Broadway	. Bel Air.	MD 21014		
		0.0	shock, or heart failure. List only Immediate Cause (Final	plications that caused the death. Do not e one cause on each line.	mer the mode of dying, such as t	ardiac or respiratory arr	Interval Between Onset and Death		
	Physician / /Medical		disease or condition resulting in death)	a. BREAST CANCER Due to (or as a consequence of):					
	Examiner		Conventible list and distance	h					
/	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause prisease or injury	Due to (or as a consequence of):					
V	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a consequence of):					
68760,	sician buria	ल		d					
687	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic		u,					
Вох	leath certific attending pl	an/IV	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	E⊏ctopic pregnancy		23d. Date of delivery Month Day Year		
	at the dea by the at stached fo	sici	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		Other (specify)		Month Day Teal		
P.0	that the	Be Completed by Phy		ontributing to death but not resulting in the	outing to death but not resulting in the underlying cause given in Part I. 23e. Did toba				
Records,	tuires tha n signed I					1 □ Y	es 2 No 3 Probably 4 Nown		
000	aw require s been sig					24a. Was a			
Ä	The lav					—— autop: perfor 1□ Yes	prior to completion of cause of death? 2 ▼ No 1 □ Yes 2 □ No		
Vital	Physiclan: Th r this certificate ral director, pag		25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
or	Physi rthis o	2	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpati		- 1	ence 6 NOther (Specify) HOSPICE		
	dlng h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury					
Division	for Atten after deat Director:	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, n. State)		
Ö	ital or rs afte ral Dir led in l	Certification:							
	the Hospital hin 24 hours s the Funeral I	edical	(Check only 2 Medical Exan	ysician: To the best of my knowledge, de niner: On the basis of examination and/or					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	2	29d. Date signed (Month, Day, Year)		
	⊢ s ⊨ ŏ		1	1_	17437	25	2/21/08		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	ク		DR. TARIQ MAHMOO		LEY RD. TIMONI	UM, MD 2109	3		
25	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7	32. Registrar's Signature	Locales .				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 9:45 PM ZWS 16 iana /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner etimore HOPK | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01/12/1938 (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F "YORK 70 NEW 094-30-5073 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 Yes 2 No Funeral Director KENT DELAWARE CAMDEN 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 19934 47 NORTH LAUNDEN LANE USA 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY PARISH SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES A. TAYLOR JULIA CARRINGTON ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 1 ASPEN STREET STROUDSBURG, PA. KELLEY NAPOLI (DAUGHTER) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 MRemoval from State ROSE OF LIMA 02/20/08 FREEHOLD, N.J. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknow þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autops, performed page 2 certificate | 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Yes Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical

Division or Vital Records, Hospital or Attending within 24 hours after death To the Funeral Director:

State Registrar

Pratz 31. Date filed (Month, Day;

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

when Hospital Lew N. Wolfe St.

29c. License number

29d. Date signed (Month, Day, Year)

2128

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Registrar

State of Maryland / Department of Health and Mental Hygiene

1- Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 22 Month Year **Physician** Herbert Moise 5:00 AM ebruari 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore Date of Birth (Month, Day, Year) Nov. 17, 1928 If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 79 102-34-1459 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Baltimore 1 √Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3732 Greenmount Avenue 21218 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married African American 1 ☐ Yes 2 ☐ No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) photgrapher insurance company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Riginal Moise Reginald Moise Sarah Colymore ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith Moise / Daughter 3732 Greenmount Avenue; Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 02/26/2008 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Steet; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cornaco ac /Medical Due to (or as a conse un nce of) Examiner SERTENSIO Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month ō Day Year in the past 12 months? 5 ☐ Other (specify) 2 No the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**V** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: after death filled in by within 24 hours a To the Funeral C

the

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 7 7 5 3 7

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALUI

32. Re

th (Hem 23a) (Type, Print)
1600 W. MOUNT ROYAL Are Ballo M) 212-17

State Registrar

DHMH 17 Rev 1/2001

ical

		1 - State Of Ma Registrar	-	rtificate of Death		giene Reg. No. 200	3 05859			
Physician		Decedent's Name (First, Middle, Last) Vivian Isis Moaney		2. Date of De Month	Day Year					
/Medical Examiner		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	Tebrua ath	4c. County of De	W			
And the second second second		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hr	S 8 Date of Riv					
Funeral Director		213–26–8656 Usual Residence of Decedent	78 Yrs.	Months Days Hours Mir	October	11, 1929 9. Bi	rthplace (State or Foreign Country) MD			
yland how at		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits			
ne Mar 8a-f s	Director	MD		Baltimore			1 X Yes 2 No			
th with the 23a or 2	al Dire	10e. Street and Number 1610 Normal Avenue		10f. Zip Code 21213		10g. Citizen of What C	1			
al", c	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent E Armed Forces? 15 Was Pecedent E Armed Forces? 17 Was Pecedent E Armed Forces?	0	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 IN No Specify:	Specify Yes or No erto Rican, etc.)					
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Busines	s/Industry			
d withii giene. rr than the M	ф	Elementary/Secondary (0-12) College (1-4or 5-12)	+}	k operations manager		Equitable Ba	ank			
be file tal Hy d othe event,	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na		e, Maiden Surname)				
hould Mer marke		Rufus Gardner 19a. Informant's Name/Relationship (Type. Print)	19h Maili	ng Address (Street and Number or I		Tutman her. City or Town. State	Zin Code)			
and 2 sealth ar		Valerie Coles / Daughter	1	921 Saint Paul Street						
Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) 11ey Mem. Gardens 0	Date 2/29/2008	20c. Location - City of Baltimore, Ma				
permit. Departi Importa any inji		21. Signature of Funeral Service Licensee		2. Name and Address of Facility 638 N. Gilmor Street	-	Funeral Home,	P.A. 21217			
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)								
/Medical Examiner		resulting in death)	consequence of):	Mortio			12 1000			
A 1	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	M 11		- \ -	= 2 aug			
ecuted and -transit	Examiner	that initiated events	e Puln	nonary Hy	perten	nsion	yrs</td			
tificate be executed g physician and as the burial-transit	edical E									
		IF FEMALE:					U			
The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year			
quires that n signed b		Part II. Other significant conditions contributing to death but	t not resulting in the u	underlying cause given in Part I.		tobacco use contribute Yes 2 No 3	to the cause of death? Probably 4 Munknown			
ician: The law recertificate has bee					24a. Wa - auto per 1□ Yes	formed? 🛴 death	autopsy findings available o completion of cause of es 2 \sum No			
cian: ertifice		25. Was case referred to medical examiner?			eath (Check only					
Physi r this o		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Patier 27. Manner of Death 28a. Date of Injur				sidence 6 Other (S) how injury occurred	pecify)			
ath. or: Afte	ation	1 Natural 5 Pending (Month, Day 2 Accident investigation		Work? M 1 ☐ Yes 2 ☐ No						
al or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju building, etc	ry - At home, farm, st . (Specify)	treet, factory, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,			
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) 1 ertifying Physician: To the best of the desired properties o	examination and/or i							
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	0111		Date signed (Month, Day, Year)			
		1 your summ	MD	AT2438	946	Februari	25,2008			
3	30. Name Andress of person who completed cause of death (Item 23a) (Type, Print) Zewif S. Barnes MD Union Memorial Hospital M						MIS			
Sta Registr		31. Date filed (Month, Day Year) 7 2008 32. Figistra	r's Signature	grand .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08-01630 Richard Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

Nonard Moore	1- For State Registrar Certificate	e of Death	Reg. No. 2008 0586							
Physician/	1. Decedent's Name (First, Middle,Last)		Date of Death 3. Time of Death							
Medical Examiner	Richard Moore 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day Year 2038 hrs debruary 25, 2008 2038 hrs							
	Laurel Regional Hospital	Laurel	Prince George's							
Funeral Director	5. Social Security Number Un K 6. Sex 7. Age (In yrs. last birthda	Months Dave Hours Min	Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) July 19, 1970 MD							
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		10d. Inside City Limits							
faryland taryland taryland taryland taryland taronce,	l Raltimore I	Baltimore/ Edgewood	1 Yes 2 No							
11445 ath with the Maryland tems 23a or 28a-f sh st be notified at one neral Director	4731 Coralberry Court	10f. Zip Code 21001	10g. Citizen of What Country?							
r death with or Items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2.XX No	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 								
s after d rral", or niner m	Wildowed 4 Divorced in Yes, Give Year or Dates:	Yes 2 X No specify:	Specify: Black							
"natur Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of work ng most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry							
5-0036 ed within 72 hour offgene. offgene. the Medical Exan	Schieffer (14 of 34)	salesman	King Tut Jewelry							
21 be fill mtal fi rrked ent, i	ol Charles Chase		st, Middle, Maiden Surname) iry Moore							
and 2 should tealth and Me tem 27 is ma traumatic ev	P 19a. Informant's Name/Rejationship (Type, Print) 19b. N Mary Moore / Mother 473	ailing Address (Street and Number or Rural B1 Coralberry Court; Edgew	Route Number, City or Town, State, Zip Code) 1000, Maryland 21001							
nore, MD ages I and 2 sho nt of Health and tt: If iten 27 is other traumati		sposition (Name of cemetery, Da or other place)	ate 20c. Location - City or Town, State							
Baltimore, Permit. Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: King Me	morial Park 02/27/								
Baltir permit. I Departm Importa	21. Signature of Funeral Service Licensee	_	e Funeral Home, P.A.							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Heart Disease complicated by Acute Chronic Between									
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death) Pericarditis Due to (or as a consequence of):	Discuss complication by his	ute Urronic Between Onset and Death							
<u>.</u>	Sequentially list conditions, b.									
led Insit	cause. Enter Underlying Cause (Disease or injury that initiated									
ransit										
760, cate be execu physician and the burial - tra	X unpended ☐ amended23a,Pt.II,27 per	ME g878 4/8/08 amh								
3760, ificate be g physici s the buri	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year							
b. Box 687 the death certific by the attending p ched for use as th	past 12 months? past 12 months?	Other (Specify)								
b. Bc the dea	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?							
P.O es that igned be deta			1 Yes 2 No 3 Probably 4 ✔ Unknown							
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly ertification: To Be Completed by Perfification: To Be			24a. Was an 24b. Were autopsy findings available prior to completion of cause of							
teco The Taw ate has age 2 s			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
ician: Certific	25. Was case referred to medical	26.Place of Death (Check only	one)							
of Vir Physic er this ral dir	1 Vyes 2 No Inpatient 2 V ER/Output		ome 5 Residence 6 Other:							
on o ending ath. or: Aft he fune tion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Tim	1 Yes 2 No	. Describe now injury decarred							
Division of Vital Rec spital or Attending Physician: The hours after death. neral Director: After this certificate filled in by the funeral director, page Certification: To Be Con	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	street, factory, office building, etc. 28f.	. Location (Street and Number or Rural Route Number, City							
Di spital hours a neral J	4 Homicide determined (Specify) 29a. Certifier 4 Continue Physics Total by Advisor Applications (Specify)		or Town, State)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated.	stigation, in my opinion, death occurred at the								
Š	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)							
	30. Name and address of person who completed cause of death (Item 23a)	J.O.IVI.E.	February 26, 2008							
		11 Penn Street, Baltimore, MD 212	201							
State Registrar	31. Date filed (Month, Day, Voar) 2008 32 Registrar's Signature	and a								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY JOSEPHINE O, SULLIVAN Z009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CLARE COURT CONVENT BALTIMORE If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/20/1916 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗶 F IRELAND 220-04-5552 91 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at MD 1 Yes 2 No Director BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3725 ELLERSLIE AVE. 21218 USA Funeral items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 No þ Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) 12YRS College (1-4or 5+) COOK COOK and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS O'SULLIVAN HANNA BUCKLEY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trauonce. SISTER JODEAN (PERSONAL REP) 3725 ELLERSLIE AVE BALTO., MD. 21218. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition f Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOTHERHOUSE CEM. 02/28/2008 BALTO. CITY,MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. JENKINS & SONS O YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infacction Myocardial **Physician** h /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician ar s the burial-t Due to (or as a consequence of): Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 I Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No certificate has the 24a. Was an was a autopsy performed? Ves 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tyes 2 | ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

Carla waf 31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Palle

Rossonthal M.D. ,3414 5

liotertual MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul St, Baltimore MD

29c. License number

D3025

29d. Date signed (Month, Day, Year)

February 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month RICHARD DANIEL PERRY 12:05 M 68 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death 4c. Franklin Square 0 5. Social Security Number Under 1 Year onths Days 9. Birthplace (State or Foreign Country) MARYLAN D Date of Birth (Month, Day, Year) 1 M 2 ☐ F 48 Hours Min 74 25-1959 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 CARDINAL 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HANDYMAN Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PERRY ALVIN くってんしつこと DAVIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD, BALTIMORE, MD 21221 DENNIS L. PERRY BROTHER 510 RIVERSIDE 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ARDEUT CREMATION 103-27-08 HANOUST, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21026 Laura C. HardesTy M-01197 ARDENT CREMATION 7522 CONVELLEY DR. N. HANDUGR, M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EXSangunatio Due to (or as a consequence of): disease or condition resulting in death) Dreed Sequentially list conditions, if only leading 1 mm of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alcoholic Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28h. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

requires that the death certificate be executed アイル アーDivision or Vital Records, P.O. Box 68760, or Attending Physician:

attending physician and for use as the burial-transit signed by the a certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

"natural", or Items 23a

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.

permit. Pages 1 Department of H Important: If it any Injury or o

is marked other

item 27

Physician

/Medical Examiner

21215

Maryland

Baltimore,

Director

Completed by Funeral

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

State Registrar 29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

who completed cluse of death (Item 23a) (Type, Print)

9000 Franklin Squardrive Balto Md 21237 Dr.

31. Date filed (Month, Day, Year)

7 2 2003



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month 9:45 pm February 2003 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number 5 ykesville OPPER alkel If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1□ M 2⊠ F Months Days Yrs. 215-56-1986 Feb 25, 1916 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Carroll County Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road 21784 **USA** 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Valentine Junker Elfriede 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 E. Lake Avenue, Baltimore, Maryland 21212 of Disposition (Name of Date 20c. Location - City or Town, State Bradford C. Peabody (Son) 20a. Method of Disposition
1 □ Burial 2 ACremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 2/27/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign here of Funeral Ser, ice Licensee 22 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STAGE DEMENTIA Immediate Cause (Final disease or condition resulting in death) cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ours efter death.

erai Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trensit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To the Hospital or within 24 hours of To the Funeral D

Physician

/Medical

Examiner

Director

Completed by Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

and Mental Hygiene.

nt of Health a : If item 27 is r or other tra

Department of Important: If any injury or

Physician

/Medical Examiner

> Physician/Medical Examiner þ edical Certification: To Be Completed completely

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2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd Elders puz MD 21784

State Registrar

FEB 2



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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Evantment in ust be inclined at angle.	by	1 ☐ Never Marr 3 🎇 Widowed	ied 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🕅 No	Specify:		,	Specify	v-	hite
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<u>S</u>	lor A after Direction by	Certification:	4 Homicide	determined	building, et	c. (Specify)		001, 14010-1, 1		City	or Town, S	itate)		
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DH	MH 17 Rev 1/2	001				-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** JOHN DUANE REYNOLDS FEBRUARY 2008 20, 17:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days M 2 ☐ F Director 217-16-5204 84 June 1, 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; if item 27 is marked other than "natural", or liems 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2√2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code aryland 21215-0036 P M 718 Towne Center Drive Funeral 21085 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ➡No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be filment of Health and Mental Hiant: If item 27 Is marked oth Maple P. Reynolds Grace Duane Rouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2704 Stevens Court, Baldwin, Maryland 21013
Disposition (Name of Date 20c. Location - City or Town, State Lloyd L. Bradford III / Step Son permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 2-25-08 Havre de Grace, MD 21. Signature of Funeral Service Licenses McCondsdFurieral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sudden - cardiac Physician death /Medical Due to (or as a consequence of) Examiner arterv oronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pertension Due to (or as a consequence of): cholesterolemia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours a er death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1240365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Chesapeake Or Beldir MO 21014 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

08-01502
Clinton Rodgers

linton Rodgers	State of Maryland / Department of 1- For State Certificate of	Health and Mental Hygiene Death Reg. N	2008 0586
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
ledical Examine	Clinton Rodgers Clinton H. Rogers	Month Day February 21,	2008 U923 TIIS 4c. County of Death
Tr.	4a. Facility Name (if not institution, give street and number) 2209 Westwood Ave.	Baltimore	N/A
Funeral Director	5. Social Security Number 0 4 5 - 3 6 - 7 8 5 1 1	If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min. 10/26/	1
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he Maryland tor 28a-f show	10e. Street and Number	Ton. Zip oddo	Citizen of What Country?
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rs afte	or Dates:	nt's Usual Occupation (Give kind of work done 16	Sb. Kind of Business/Industry
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2121 should be fi and Mental is marked atic event,	19a, Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural Route Numbe Edrman Ave, Balt., M	
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MOF6 Pages I ent of F int; If	1 Augura 2 Cremation 5 Removal non-state Garriso	n Forrest 2/29/08	Owings Mills, MD
Baltimore, permit. Pages I ar Department of Hee Important; If ite injury or other tr	21. Signature of Furieral Service - Trensee 22. I	Name and Address of Facility Hari P. Cl 26 Belair Rd, Balt.,	lose F.Svs,PA
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and
(aminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Congestive heart failure		Death
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	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
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Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certificate rs after death. "In Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the tent in by the funeral director, page 2.	23b. Was decedent pregnant in the past 12 months?	Tetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
O. B at the da 1 by the tached		G. I. G. I. J. I.	acco use contribute to the cause of death?
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	27. Matural 5 Pending (Month, Day, Year) 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify)	reet, factory, office building, etc. 28f. Location (St or Town, Sta	treet and Number or Rural Route Number, City ate)
hou hou		curred at the time, date and place, and due to the cause	e(s) and manner as stated.
To the H within 2- To the F	(Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurred at the time, date a	and place, and due to the cause(s)
F S F S	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) February 22, 2008
	Hamen Gorethall, Mis	O.C.M.E.	, obidary 22 , 2000
== /6	30. Name and a ress of person who completed cause of death (Item 23a) Parnela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	
Sta	20 D. Avada Signatura	Casto	
Regist	rar FEB 4 1 2000 Feb 2000 p		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11 tem 30 per dvr 9876 2-28-08 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jay 1-00P M **Physician** ,2008 - Cona /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1 M 2 F 212-48-9044 03/01/1915 MD Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h. County 10a State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No OWINGS MILLS Directo BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 6 STRONGWOOD ROAD Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, O... Year or Dates: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MARYLAND CUP COMPANY ASSEMBLY WORKER permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, <u>the</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAPLAN MINNIE CHAIT HARRY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12209 WOODELVES DRIVE, OWINGS MILLS, MD RHODA FRIEDMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 02/26/2008 HEBREW YOUNG MENS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) for use as the burial-Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) as been signed by the a 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐Unknown 2 1 NO 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has death? 1 ☐ Yes 2 No 1☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 III Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of completely filled in by the funeral 27. Manner Teath 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 ☐ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0052950 February 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Lamont Charles Smith Northwest Hospital Center 32. Regis 31. Date filed (Month, Day, Year) State Registrar

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	/Medic Examir		4a. Facility Name (If not institution, give street and number,		4b. City,	Town, or Loca	ation of Death		4c. County		
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pu	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last)			18. I		(First, Middle, M		,	
Maryland	should and Men marker	2	George L. Silate 19a. Informant's Name/Relationship (Type. Print)	101	b. Mailing Address	(Street and A		1ez G			0-4-1
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<u>E</u>	nit. Pages artment of l ortant: If its injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Onation 5 ☐ Other (Specify)		ny Gifts Re		February	24,2008	Hanou	er, MI	7
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		22. Name an	d Address of I	Facility And	stomy Gif	Hanove	try mo	21076
			23a. Part1. Enter the disease, or comp to ill ris in at cause shock, or heart failure. List only one cause on each I	d the death. Do ine.	not enter the mod	e of dying, suc	ch as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	jury - At home, fa tc. <i>(Specify)</i>	arm, street, factory			28f. Location (St City or Town	reet and Num n, State)	ber or Run	al Route Number,
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	Y		30. Name and address of person who completed cause of	death (item 23a)	(Type, Print)	DN-	441	(10 B	node 1	Mn -	106.1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 | 3 Amend Items 17 & 18 per Beetiffcate of Death reg. 7/7/0789-**8**81 dk 3. Time of Death 1. Decedent's Name (First, Middle, Last) HEBRUARY DE 5, 2008 **Physician** Shirley Bertha Edier Selander 5:10A /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Maryland 1 ☐ M 2 🔀 F March 21, 1926 81 215-03-5822 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Lutherville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21093 204 Rothwell Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White <u>≽</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Wilson Edica James Edler P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant; If item 27 Is Lutherville, MD 21093 Thelma Seagle Rothwell Drive 1 sister other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or ¥ ö February 25,2008 Hanover, MD Anatomy Gifts Registry 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signat e of Funeral Sevice Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications limit caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of): CONGESTIVE HEART FAILURE Examiner 5-quentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pate has been signed page 2 should be det Division or Vital Records, þ 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed? Yes 2 No certificate 10 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mohla mo mder 24 Wy 25 2008 D41410 30. Name and 3 dresslof person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE. TOWSON, P MEHTA M.D. 7601 JOGINDER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2008 Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Year 0313 PM Kaymond 24 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HODKINS HOSPITA Baltimore Johns 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 65 Director 237-62-8888 05/30/1942 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 XYes 2 No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a (must b 21207 U.S.A. 4806 Haddon Funeral Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian . Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: ō 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City dother than ' Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Department Chief 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasper Short Lillian T. Langley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 <u> Sandra Wright Short / Wife</u> 4806 Haddon Avenue, Baltimore, Maryland 21207 ace of Disposition (Name of Date 20c. Location - City of Town, Star 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/03/2008 | Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate val Between et and Death Immediate Cause (Final

Physician /Medical **Examiner**

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

the certificate ha Director: within 24 hours a To the Funeral D

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Respiratory Divivers Syndrome disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 2 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 ER/Outpatient 3 DOA မ 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Natural
Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Thomas

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01511 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 21, 2008 1340 hrs Medical Examiner LEWIS STANBACK JOHN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Min. Months Days Hours Country) Director Yrs 1 X M 3.0 226 46 6595 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Ę 1 X Yes 2 No BALTIMORE N/A MD other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2003 E. 30TH STREET 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 X Married Yes Yes 2 X No specify: SpecifyBLACK If Yes, Give Year Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) within 72 l Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than or other traumatic event, the Medical or other traumatic event, the Medical Baltimore, MD 21215-0036 BALTIMORE CITY 9TH Heavy Equipment Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIRGINIA Macklin LEWIS STANBACK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 21218 RUBY STANBACK 2003 E.30th St. Baltimore, Md. (wife) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State WESTERN STAR FEB.29,2008 BALTO.CO,MD. permit. Page:
Department o
Important: Donation 5 Other Specify 22 Name and Address of Facility
ALVIN B. SCRUGGS FUNERAL HOME
412 E. PRESTON ST. BALTO, MD. mure of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death (Medital Immediate Cause (Final disease Cocaine intexication taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a.PII.27.28a-f. perMF.9877, 3/4/08 TT 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 🗸 Unknown 2 Atheosclerotic cardiovascular disease Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has page 2 ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director. æ Other; Hospital: Residence 6 Other: examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 y No 1 Natural 5 Pending 2/21/2008 FNd 12:30 pm Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
808 N. Belnord St. 6 X Could not be 3 Suicide Baltimore.MD determined (Specify) friend's home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 22, 2008 O.C.M.E. 30. Name and address of person who completed suse of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 31. Date filed (Month By, 1997) egistrar's Signatur State 2008 Registra

JOHN LEWIS STANBACK

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WILLI AMS 21 2009 /Medical 4c. County of/Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALIMONE JOHN'S HOPKINS BAYLIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, **Funeral** Days 1 ☐ M 2 🗷 F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Md. Director more 10g. Citizen of What Country? 10e. Street and Number Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 □ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced er than "natur , the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ?7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) To Be 19a. Informant's Name/Relationship (Type. Print) (doughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/29/2008 1 X Burial 2 □ Cremation 3 □ Removal from State orraine Park 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ral 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 HOURS Physician hESPIMATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VI MAL Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1 TYes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? after death. I Director: After the (Month, Day Year) 5 ☐ Pending investigation 1 🖳 Natural 1 □ Yes 2 □ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOTTA

BALTI Mohit

29c. License number

MES-000

29d. Date signed (Month, Day, Year)

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			For State	State of Maryland				lental Hy	giene		- 174 O Mg (III
			■ Registrar		Cei	rtificate of I	Death		Reg. No.	2008	05875
	Physici	_	Decedent's Name (First, Middle, Lass Baby Boy Wate					2. Date of De Month Februar	Day	6 ZOOS	3. Time of Death
	/Medic Examin	Company of	4a. Facility Name (If not institution, give	street and number)		- 1	Location of Death			County of Death	
c 		2 0	The Johns Hopki		4 b i-4b -lov4	Balthy If Under 1 Year	nou Cit	8. Date of Bir	***	0.5:0	(2)
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex	Yrs.	Months Days	Hours Min. 2 26	Feb 16	y, Year)	Coun	
	pui »		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	ecation					0d. Inside City Limits
	Maryla f shov led at	ō	MD		Baltin						1 Yes 2 No
	ith the or 28a-	Oirec	10e. Street and Number	t		10f. Zip Code	1010		10g. Citiz	en of What Cour	itry?
	leath w ns 23a must b	Funeral Director	1917 Montpelier S	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	1218 Ispanic Origin? (Sp	ecify Yes or No)n 1	USA 4. Race - Americ	
036	urs after d al", or Iten Examiner	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		If Yes, specify Cuba 1 ☐ Yes 2🌠 No	an', Mexican', Puerto Specify:	Rican, etc.)		Black, White, Specify: bla	
215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kir	nd of Business/Ind	dustry
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and	0 7 5	To Be	17. Father's Name (First, Middle, Last)			unk		nta Wat		Surname)	
Maryland	nd 2 should be Ith and Mental 27 is marked of r traumatic ev	-	19a. Informant's Name/Relationship (The Johns Hopkin			ng Address (Street) N. Wolfe					′
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic er once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🛣 Other (Specification of the control of the contro	Removal from State	lace of Dispo emetery, crea	osition (Name of matory or other plac		Date	20c. Lo	cation - City or To	own, State
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Stylice Licer	Wave Jirector		2 Name and Addre tate Anat altimore,			. Bal	timore S	Street
Ď.			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death one cause on each line.					rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. Extreme	Pren	naturity					Onset and Death 36 MINUTES
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C. Box	that the death certifined by the attending of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify) _	/			Month	Day Year
'n.	ss that I	by Ph	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.	23e. Did 1	tobacco u	se contribute to the	he cause of death?
ord	w requires to been signer should be							1 🗆	Yes 2	Mo 3 Prob	oably 4 Unknown
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Ö	Dis D	To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	III 3 L DOX	4 LI Nursing H	ome 5 ☐ Resi 28d. Describe		Other (Specity occurred	(y)
lo l	inding Fath. r: After re funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2 □ No				
Division	il or Atte after dea I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (City or To	Street an wn, State	d Number or Rura)	al Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To th within To th comp	Me	29b. Signature and title of certifier	2		29c. Licens	e number			e signed (Month,	
			1 Back	MD		D6	6161		02	-16-20	08
			30. Name and address of person who LINDA 5ZYMAN	completed cause of death (Item		Print) OLFE 5	T. 184	JIMOI	TF.	MD 7	1287
*	Sta		31 Date filed (Month Day Year)	32. registrar's Signa		foods	12/1	7/10	-,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:35 P. Mary Ann Walker <u>February</u> 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 606 Cromwell Street Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 ▼ F 175 52 9031 45 June 2. 1962 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any lighty or other traumatic event, the Medical Exception 1. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2x ☐ No Maryland Anne Arundel Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 606 Cromwell Street 21225 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Never Married 2X Married ☐ Yes 2 🙀 No Yes, Give 1 ☐ Yes 2 🗓 No Specify: White ρ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Teyssier Virginia R. Wappes 19a. Informant's Name/Relationship (Type. Print)
Kevin Walker / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Cromwell Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 102/26/2008 Glen Burnie, Maryland 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Fundral Service Li 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 162 static /Medical Due to (or as a consequence of): Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2/2/No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♠No 24a Was an certificate has 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 ☐ Inpatient 2 this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

(Type, Print)

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×		A	Greater Balti: 5. Social Security Number		ge (In yrs. Ia		Towso		rs. 8. Date of Bir			elace (State or F	Foreign
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	or 28	Directo	10e. Street and Number		·		10f. Zip Code			10g. Citizen of W	hat Cour	ntry?	
	th will		2512 Pleasant	ville Road			2104	17		USA			
	dea	Funeral	11. Marital Status	12. Was Decedent		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No	- 14. Race	- Americ	an Indian,	
9	after or it		1 Never Married 2 Mar	ied 1 ☐ Yes 2 🔀 If Yes, Give			1∐Yes 2XINo	Specify:	,				
15-0036	be filed within 72 hours after death with the Maryland that lygiene. A other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Whi		
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Maryland 21	should be and Mental s marked umatic ev	ျှ	19a, Informant's Name/Relations			19b. Mailir	ng Address (Street				State, Zip	Code)	
<u>S</u>	and 2 sealth ar		Terry S. Warfi	ald / Wife	i	2324	Baldwin	Mill Ro	nad Fall	ston MD	210	17	
ā,	- 子 h 幸		20a. Method of Disposition	cia / Wilc	20b. Pla		esition (Name of matory or other place		Date	20c. Location -			
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<u>_</u>									1□ Yes	2 No 1	Yes	2 No	
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ō	Phys	٦.	1 Yes 2 No 27. Manner of Death	28a. Date of Inj		R/Outpatier 28b. Time o	" OLI BOX	4 LI Nuising	Home 5 ☐ Resi	dence 6 Other		fy)	
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DIVISION	Atten deatl ctor: y the	lical	3 Suicide 6 Could	at he	jury - At hon	ne, farm, str	reet, factory, office		28f. Location (Street and Number	er or Rura	al Route Numbe	er.
2	after after Dire	Certification:	4 ☐ Homicide determ	building, e	tc. (Specify))			City or Tò	wn, State)			
	spita nours nera y fille			ng Physician: To the besi									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification property in the Funeral Director after the completely filled in by the funeral director, the funeral director, and the funeral director.	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s		on and/or in	ivestigation, in my o	opinion, death of	ccurred at the time	, date and place, a	and due t	o the cause(s)	
	To th within	M	29b. Signature and title of certifie	r			29c. Licens	e number		29d. Date signed	(Month,	Day, Year)	
)			manie (later			DZ	090	7	2/24	1/0	Y	
	B		30. Name and address of person	who completed cause of	death (Item	23a) (Type,				100000000000000000000000000000000000000		^	
			Marie	Chathan		671	01 20 01	lacles	St . B.	llenon	e, l	id a	1206
	Sta		31. Date filed (Month, Day Year)	2008 32 Regist	rar's Signati	ure	ask s		,		*		/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Martina F. Yockel 7:15 A. 2008 February 25, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4200 Ritchie Highway Anne Arundel Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 220 09 6333 93 April 2, 1914 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Maryland Anne Arundel **Baltimore** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4200 Ritchie Highway U.S.A. 21225 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Insurance Company 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Elliott Martin Yockel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 William Yockel / Nephew 4200 Ritchie Highway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Cedar Hill Cemetery 02/27/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Juneral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage **Physician** kona /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALZITET MER DIMENTIA Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No has e 2 certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this : After this funeral of 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Certification: Injury at Work? (Month, Day Year) Injury or Attending 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation М death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1445931 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET RESTERSTOWN 25 MAIN 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

izabetii C. Tar		State of Maryland / 1-For State Registrar	Certificate		u Mentai ri	yglerie Reg.	No. 200	8 0587
Physici	an/	Decedent's Name (First, Middle,Last)	λ			2. Date of Death Month D February 25		3. Time of Death 0550 hrs
ledical Exami		ELIZABETH CAROL YAREM 4a. Facility Name (if not institution, give street and number)	A	4b. City, Town, or	Location of Death		4c. County of Death	
		Greater Baltimore Medical Center		Towson			Baltimore Cou	-
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 F	(In yrs. last birthda	y) If Under 1 Year Months Day			(MM/DD/YYYY) ^{9. Bir} /1969 MA	thplace (State or Foreign ountry) RYLAND
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
A ,	٦	MD BALTIMORE	WHIT	E HALL				1 Yes 2 No
e Maryland or 28a-f show Ged at once.	Director	10e. Street and Number 19628 GRAYSTONE RD.		10f. Zip Code 2 1	161	10g	. Citizen of What Cou USA	intry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menlal Hygiewith and Menlal Hygiewith and "natural", or items 23a or 28a-f she 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	Funeral D	11. Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S. 13	3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp			ican Indian, Black,
ler dea ", or it er mus		3 Widowed 4 Divorced If Yes, Give Year	No .	Yes 2 No	specify:		Specify: WH	ITE
ours af	d by	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Dec	edent's Usual Occupa	ation (Give kind of		6b. Kind of Business	Industry
36 hin 72 h e. than "r edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5 +)+)	rorney		,	LAW	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than		17. Father's Name (First, Middle, Last)	<u> </u>			e (First, Middle, Ma		
2121 Suld be fi Mental J marked	To Be	CARL YAREMA 19a. Informant's Name/Relationship (Type, Print)	19b. M	laiting Address (Stre		R MCGIN	er, City or Town, State	e, Zip Code)
e, MD 2 1 and 2 shou Health and I fitem 27 is retraumatic		CARL YAREMA (FATHER)	70	5 INDIAN	SPRING	CT. SP	ARKS,MD.	21152.
= 8 8 = 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	ite crematory	isposition (Name of co or other place)			20c. Location - City o	
- E 27 P		Donation 5 Other Specify: 21. Signature of Funeral Service-Licensee	ST. J			/01/08	MONKTON	, MD.
Balti permit. Departn Import injury	11 1	Willer (Lauss)	Ĩ	22. Name and Addres TENRY W• 16924 YO	RK RD M	ONKTON,	MD. 2111	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.			, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Occlusive Pulm Due to (or as a conse		embolism				
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ecuted and transit	ŭ	events resulting in death) Last Due to (or as a conse	equence or):					
l	Medical	UNPENDED AMENDED						
8760 lificate ng phys	n/Me	IF FEMALE: 23c. If yes, outcor 23b. Was decedent pregnant in the	ne of pregnancy	Fetal death 3	Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
tox 68760, eath certificate be eatending physicia for use as the buria	sician/I	past 12 months? 1 Yes 2 No 9 ✓ Unknown g Unknown	time of death 5	Other (Specify)				
O. B. at the de lby the	Physic	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause	given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
S, P.C nires that signed d be deta	ed by							obably 4 Unknown
cords law requ has been	Completed					24a. Was ai autops perform	y prior to	autopsy findings available completion of cause of
tal Rec tian: The l certificate !		25. Was case referred to medical		26 Pla	ce of Death (Check	1 ✓ Yes 2		
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1 of Jing Ph After t funeral	Certification: To	27. Manner of Death 28a. Date of Inju (Month, Day, Y	ry 28b. Tim ear)		ury at Work? Yes 2 No	28d. Describe ho	ow injury occurred	
ivisior or Attencafter death Director:	icatio	2 Accident Investigation 28e. Place of In	iurv - At home, farm.	street, factory, office		28f. Location (St	reet and Number or R	Rural Route Number, City
Divis pital or At ours after d ceral Direc	ertif	3 Suicide 6 Could not be determined (Specify)			5.	or Town, Sta		
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner.	y knowledge, death mination and/or inve	occurred at the time,	date and place, and on, death occurred	d due to the cause at the time, date a	(s) and manner as stand	ated. the cause(s)
To To Com	Medical	and manner stated. 29b. Signature and title of certifier			se number		29d. Date signed (M	
		Quest 2 "		0.0	.M.E.		February 26, 20	800
10		30. Name and address of person who completed cause of a Ana Rubio MD. Assistant Medical Exam		nn Street, Baltim	ore, MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	nerth)	· · · · · · · · · · · · · · · · · · ·			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Parthena Zois 11:40 25, 2008 February /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | December 5, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F 218-31-3913 78 Greece Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumaft event, the Medical Examiner must be notified at any injury or other traumaft event, the Medical Examiner must be notified at 1 □Yes 2 No Maryland Baltimore Director Overlea 10a. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 21206 17 Morning Star Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mantal Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Housewife</u> Own Home 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gregory Anthimidis Sasa Antoniadis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Morning Star Court, Overlea, Maryland 21206 Daughter Chris Giftopoulos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February Marial 2 ☐ Cremation 3 □Removal from State Oak Lawn Cemetery 28, 2008 Dundalk, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. mtho 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or & a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, placed of the property of that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Physician/Medical the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

law requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Hospital or Attending Physician:

within 24 hours at To the Funeral D

completely

Maryland 21215-0036

Baltimore,

certificate has been signed by rector, page 2 should be detact Completed funeral director, Be Certification: To After this after death Director: filled in by

autopsy performed? 2 0 No

26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

1 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

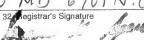
29c. License number B0051347 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

6701 N. Charles ST Bal himore MD 21204 MI) Joriann 31. Date filed (Month, Day,

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Date c. Month 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day me /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PININSULA Marra KegINOL CENTU WIOIMIO If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 X M 2 □ F Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notitied at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 18 CEN Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lest 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 Removal from State 2-16-08 4 Donation 5 Dother (Specify) es/cy Cem 22. Name and Address of Facility BCAN C Tunera Legice Lice 21. Signati Box 331 POCOMOKO 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin Physician disease or condition resulting in death) avour /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Death 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

ONSTANTE

31. Date filed (Month, Day, Year)

CARROLL

SAlisbury Md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IAN

FEB 13 2008

100E.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Walter Atwell 17, Feb. 2008 8:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton, MD Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□F Months Days Director 232-58-2864 Usual Residence of Decedent 69 6, 1938 Raysal, 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Director MD Cecil Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 242 Main Street 21912 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iter
ury or other traumafte event, the Medical Examine. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XXNo ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Atwell Clydia McLaughlin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aileen Atwell/Wife 242 Main Street, Warwick, 21912 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State United Crematory 2/18/2008 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DF 19709 MULLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Jetsis and septic 48 Lours resulting in death) /Medical Due to (or as a consequence of): Examiner Sileof Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Eyd End Stage

Due to (or as a consequence of): physician and s the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by discose 1 ☐ Yes 2 🐪 O 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 autopsy certificate has irector, page 2 perform 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 7Ho 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: completely filled in by the f

State Registrar

5

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Uyion Hospital 106 Bowst Electon up 21921 1 Pino Mb 32. Registras Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 9 2008 >

29c. License number

00055190

29d. Date signed (Month, Day, Year) February 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#1perMD2/13/08, BMW, MoCo Certificate of Death Reg. No. ARONOFF 1. Decedent's Name (First, Middle, Last) REVA 2. Date of Death Physician EBRUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F 210-36-1399 95 Director 01/09/1913 Romania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Montgomery Rockville 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Miller Elizabeth Acker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Michael Aronoff - Son 60 Riverside Drive #16D, New York, NY 10024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Ferncliff Cemetery 02/10/2008 Hartsdale, NY 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHENIOVASCULAR DISIFIASIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🏋 No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Atter this certificate has been signed in funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No perform Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei (Check only one) 29c. License number title of certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 2 D 35436 FEBRUARY 07, 2008 ONTEOSE ROAD, RECKVILLE MD 20,85%

State Registrar Day, Year)

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2008

31. Date filed (Month,

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 24a 30 per dyr 9876 2-26-08 yt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 15, 2008 **Physician** Elmer Boyd Alley 1502 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 9/30/1924 223-28-0682 83 Virginia Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford MD Havre de Grace Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Hopewell Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver/Salesman News Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Siebert Alley Leanna Shockley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscina E. Alley (Spouse) 7 Hopewell Rd. Havre de Grace, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Mem. Gdns. 2/19/08 Aberdeen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician respiratory distress Syndrome /Medical Due to (or as a consequence of): Examiner Sepsi Securities y list constitutes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): División or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Uremia 1 Yes 2 No 3 Probably 4 Wunknown multi-organ-24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 063420 Caser February 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Medical Center Khara1

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

2008

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	Physici /Medio	cal	Decedent's Name (First, Middle, Last) JAMES As Facility Name (If the little in the last) The Continuous Continuou	W.	BI	BLE	Sr.	2. Date of De Month 02	20	Year 08	3. Time of 0402	Death M
	Examir	ner	4a. Facility Name (If not institution, give s WMHS MEMORIAL CAM			4b. City, Town	i, or Location of Dea RLAND		A	y of Death LLEGA	ŊŶ	
	Funeral Director		5. Social Security Number 215-36-9257 Usual Residence of Decedent	7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Day			1, 1937	Coun	lace (State or try)	r Foreign
	e Maryland 8a-f show tiffied at	Director	10a. State 10b. County MD Allegar		ty, Town or Lo Cum	cation Iberland				11	0d. Inside Cit	-
	th with th 23a or 24 ust be no	ral Dire	315 Arch Street			10f. Zip Code	21502		10g. Citizen of	What Coun	try?	
2-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married	12. Was Decedent Ever in U Armed Forces? 11 Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Ci	f Hispanic Origin? (suban, Mexican, Puel Io Specify:	Specify Yes or No rto Rican, etc.)	- 14. Ra Bla Specii	ce - America ck, White, e	etc.	
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, Mar	and 2 sho ealth and m 27 is m	1	19a. Informant's Name/Relationship (Ty) Melvena Bible	wife	315	Arch St		Cum	berland	M	D 2150)2
Dallinore	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of matory or other p neral Hom		Date 2/22/2008	20c. Location	- City or To aptowr		ИD
	permit. Depart Import any Inj once.		21. Signature of Funeral Service License		22		tress of Facility elli Funeral Ho irginia Avenue		nd. MD 21	502		
	1000		23a. Part . Enter the disease, to not suck, or heart failure. List only or	tions that caused the deat e cause on each line.	h. Do not ente	er the mode of d	lying, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and D	ween
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5	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					+		
00/00	ficate be physici s the bu	ledical	d									
O. DO.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3□]Ectopic pregnar] Other <i>(specify)</i>				ate of delive onth	-	'ear
, (S)	quires that signed by lid be deta	d by Phy	Part II. Other significant conditions con	tributing to death but not res		, ,	given in Part I.		obacco use con Yes 2 No			eath?
22011	: The law rec cate has bee page 2 shou	Completed by						24a. Was autor perfo 1∐ Yes		Were autop prior to con death? 1 ☐ Yes	osy findings a npletion of ca 2 No	ıvailable ıuse of
2	s certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩0	ospital: 1 ☐ Inpatient 2 🗷	ER/Outpatien	t 3 DOA	thor:	ath <i>(Check only o</i> Home 5 ☐ Resid				
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	To the Hospital or Attend within 24 hours after death. To the Funeral Director. A completely filled in by the fr	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre			28f. Location (S City or Tox	Street and Num vn, State)	ber or Rura	Route Numt	ber,
	e Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier 1 Deertifying Phys (Check only one) 2 Medical Examir	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death	occurred at the vestigation, in m	time, date and plac y opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s))
	To the within To the comp	Me	29b. Signature and iffe of certifier	PHY GC	AN	29c. Lice	nse number		29d. Date signe	ed (Month, I	Day, Year)	า <i>เ</i>
5	7		30. Name and address of person who on	mpleted cause of death (Item	1 23a) (Type, I	Print) 912	STON DE	/	MBITZ	CUM	MD 2	1507
	Sta		31. Date filed (Month Day, Year)	32, egistrar's Signa	iture							,- ~
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year February 20, 2008 Richard Bernard 1630 /Medical Eacility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) OKINS NS HO 1705 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F 203-50-6903 Yrs. Director Feb, 23,1 Pennsylvanik Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. New Castle 1 ☐ Yes 2 No Bear Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 19701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Direct 17. Father's Name (First, Middle, Last) Be Bennana S P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barnara Avc. Linda BERVI DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Name and Address of Facility 21. Signature of Funeral Service Licenses oun bery DE 19809 Phila del 23a. Part1. Enter the disease, or o shock, or heart failure. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) Physician Ischemic brain injure days /Medical Due to (or as a consequence of): Examiner Muccardial inforction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner renal failure To the Hospital or Attending Physician: The law requires that the death certificate be execu-Due to (or as a consequence of) burial Division or Vital Records, P.O. Box 68760, Physician/Medical leukemia muleloid attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tate has been signated by page 2 should by 3 Probably 4 Unknown 1 Tyes 3**√**№ Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 221No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Elizabeth Lenderman, Medical Doctor

Registrar

State

Bizabeth Lenderman, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD ZIZ87

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrary Signature

08-01318 John Baile

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician		egistrar . Decedent's Name (First, Middle,Last)	0071	- Douil		Reg 2. Date of Death		3. Time of Death	
ledical Examin	**	John Henry Baile	У				Month [February 15	Day Year 5, 2008	1420 hrs
p le	ľ	a. Facility Name (if not institution, give st				Location of Death		4c. County of Deat	h
		Western Maryland Health Sy			Cumberlan			Allegany	
Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Day			(MM/DD/YYYY) 9. Bi Forei	gn
Director		30 11 0222	2 F 82	Yı			1/30/1	926	ountry) WV
any		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	etion				10d. Inside City Limits
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Maryland 28a-f show 1 at once.	핡	WV Morgan 10e. Street and Number	Pa	aw Paw	10f. Zip Code		100	. Citizen of What Cor	untry?
or 28	Director				25434	<i>/</i> .		USA	
with the Maryland ms 23a or 28a-f sho be notified at once.	- L	89 Plaines Road	2. Was Decedent Ever in U.	S. 13. W	as Decedent of Hi	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	rican Indian, Black,
Jeath r item	Fune	1 Never Married 2 Married	Armed Forces?	lf lf	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, etc.	
after o	ğ T	3 X Widowed 4 Divorced If	Yes, Give Year r Dates:		Yes 2 X No				white
5-0036 led within 72 hours af Hygiens af Hyg		15. Decedent's Education (Specify only		16a. Decede during	ent's Usual Occupa most of working life	ation (Give kind of v e. DO NOT use reti	work done red)	16b. Kind of Business	industry
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		Laborer		ì	Baker	
-003 d withi	틹	1 Z 17. Father's Name (First, Middle, Last)			Laborer	18.Mother's Name	e (First, Middle, M		У
21215-0036 Juld be filed within 7 Mental Hygiene marked other than event, the Medica	Be C	AshbyBailey				LavinaMo			
21.		19a. Informant's Name/Relationship (Typ	e, Print)	1.7				oer, City or Town, Sta	te, Zip Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f sho armatic event, the Medical Examiner must be notified at once		John L. Bailey/son			Plaines R	Road, Paw	Paw, WV	25434 20c. Location - City of	or Town State
or Hear of Hear tr.	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3		crematory or		emetery,	Date	200. Location Oily	or rown, exact
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the 1		4 Donation 5 Other Specify:			Funeral Hon		18/2008_	Cresapto	
Salt ermit. Depart mpor njury	ļ	21. Signature of Funeral Service Lice	/// .						, P.A. for
	4	23a/Part I. Enter the disease, or complic	ations that caused the death	. Do not ente	. 1mble run r the mode of dying	eral Home	or respiratory arre	aw W Va - st, shock, or heart	Approximate Interval
Physician Medical	4	failure. List only one cause on each	line. cute Thrombosis of R						Between Onset and Death
caminer	1	or condition resulting in death)	ie to (or as a consequence o	rf):					
		Sequentially list conditions, —	ypertensive Atheroscl		diovascular D	isease			
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and trans	삘	d							
60, cate be executed hysician and he burial - transit	Physician/Medical	UNPENDED	AMENDED					-	
760, ficate be g physic s the bur	ĕ	3b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy 2	Fetal death 3	Ectopic pregn	ancy	23d. Date of deliv Month	ery Day Year
Box 6876 he death certificat be death certificat y the attending phyched for use as the	cial	past 12 months?	4 Pregnant at time of de		Other (Specify)				
Box e death c the atten	lys.	1 Yes 2 No 9 Unknown	g Unknown						to the cause of death?
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cords,	흺						autop perfor	sy prior t	o completion of cause of
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of Vital Records, ng Physician: The law requirement of the this certificate has been similared in ector, page 2 should the page 2 should the control of the	၉	1 ✓ Yes 2 No 27. Manner of Death	1 Inpatient 2	28b. Time		njury at Work?		now injury occurred	
n of oding Pl h.: After	ë	1 V Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		1	Yes 2 No			
Division tal or Attendi rs after death. al Director: /	icat	2 Accident Investigation	28e Place of Injury - At h	nome, farm, s	treet, factory, office	e building, etc.			Rural Route Number, City
Division of 'spiral or Attending Phous after death. reral Director: After Iffled in by the funeral	Certification:	3 Suicide 6 Could not be determined	(Specify)				or Town, S	tate)	
Hospi 24 hou Funct		29a. Certifier 1 Contifuing Physicia	n: To the best of my knowled	dge, death oc	curred at the time,	date and place, ar	nd due to the caus	e(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner:	On the basis of examination and manner stated.	and/or invest	igation, in my opini	ion, death occurred	at the time, date	and place, and due to	o the cause(s)
H 3 F 8	Æ	29b. Signature and title of certifier	/ ^			ense number		29d. Date signed (
		Carol	Hello	11	0.0	C.M.E.		February 16, 2	8
		30. Name and address of person who co		m 23a)	- C44 D-111	more MD 040	01		
V			t Medical Examiner		n Street, Balti	more, MD 212	U I		
St Regist	ate	31. Date filed (Month, Day Year) FEB2 7	32. Registrar's Signat	ture	Accorded)				
Regist	LL.		10000	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01342 2008 State of Maryland / Department of Health and Mental Hygiene Blaine Anthony Briscoe 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 16, 2008 0303 hrs Medical Examiner Blane Anthony Briscoe 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Indian Head Highway Route 210 at Pine Drive Accokeek 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director Country) Wash.DC 220-74-7699 Jan.25, 49 1959 1<u>x x</u>M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show Charles MD La Plata notified at once. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9755 Half Place 20646 U. S. A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married Yes Specify: Black Yes 2XX No specify: Divorced If Yes. Give Year If item 27 is marked other than "natural", her traumatic event, the Medical Examiner ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10 Construction Worker Carter Construction Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alton Austin Briscoe Luvenia May Owens (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice L. Briscoe/Wife 9755 Half Place La Plata, MD 20646 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Heart Cem. 23,2008 La Plata. Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Raymond Funl. Service, P.A. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20646 Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical UNPENDED AMENDED ed by the attending physician a detached for use as the burial -Hospital or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 굽 Part II. Other significant conditions signed to be deta Yes 2 ✔ No 3 Probably 4 Unknown ξ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✔ Yes 2 1 V Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other4 examiner? Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury After Pedestrian struck by auto Feb 16, 2008 Certification 0301 hrs Division Natural 1 Yes 2 ✔ No Pending within 24 hours after death. To the Funeral Director: filled in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Indian Head Highway Route 210 @ Pine Dr., Accokeek, determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 To the Fun Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medica and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. February 17, 2008 tooke ilep 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 31. Date filed (Month Day, Year) 32. Registrar's Signature State Sept of the sept o Registrar

DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

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_	id 2 sho lth and 27 Is ma treum		Nancy L. Bowman				rove				I Route Number, ISPORT, M	•		Code)
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	quires n sign	d by	Metratetic lun	3 acres							1/2 ¥ e	s 2 🗆 N	No 3 Prob	ably 4 Unknown
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	After funer	lon	27. Manner of Death 1. ✓ Natural 5 ☐ Pending		Day Year)	28b. Time of Injury		Work?	?		8d. Describe hor	w injury o	ccurred	
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	withir To th comp	Me	29b. Signature and title of certifier	The second contract of			29c.	License	number				igned (Month, L	
						MD	0	-00	564	13		021	13/200	8
. 1			30. Name and address of person who	completed cause	of death (Item	1 23a) (Type, F	Print)							
つん	-9+1		Sanjay Saxena M.[Opal C		Hagers	stow	n,MD	2174	0			
	Sta Registra		31. Date filed (Month, Day, Year) FEB 14	2008 32. Reg	jistrar's Signa	ture	Carall .	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g8//, 03/0/08dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Timothy Jon BECKER February -10/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
D. C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 27, 1954 1 ★ M 2 □ F 53 215-62-2935 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh notified 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 must be n 21740 USA 16944 Shady Brook Terrace Funeral iral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter various iobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius T. Becker, Jr. Stella M. Greene 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Douglas - friend 3101 Grade Rd., Falling Waters, W. Va. 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 2/15/08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee MINNICH FUNERAL HOME Boluls 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Low /Medical Due to (or as a co nce of): **Examiner** EN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a none Physician/Medical Examiner Pneumonia Unknown signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ID Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 02,12, mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSOWW, MI)

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State Registrar

DHMH 17 Rev 1/2001

shaheen

31. Date filed (Month, Day, Year)



MD

DAK HILL AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ogy Og 1205PM 02 ୬୦୭୪ 4a. Facility Name (If not institution, give street and number 4c. County of Death Was Hing WOSHINGLON 5. Social Security No. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year place (State or Foreign 213-68-6765 1 1 x M 2 □ I 49 Hours . Virginia 11,1959 West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Berkelev Director Martinsburg 1XYes 2∏No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 South Porter Avenue 25401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No white ò Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Barrett ပ Hoy Edna Elizabeth Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Barrett - wife 250 North Mulberry Street Apt 2, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 12, 2008 | Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Walut 6 415 East Wilson Blvd., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL disease or condition resulting in death) OBIOS OM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Beno! D. WAC 1 Yes 2 No 3 Probably NEUMONIX 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autops 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 \sum Nursing Home 1 🗀 Yes 2 ER/Outpatient 3 DOA Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28h Time of Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 🗆 No

Physician /Medical Examiner Examiner The law requires that the death certificate be executed and

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

traumatic event, the Medical

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injury or

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permit. Pages 1 an Department of Heal Important; If Item 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heath and Mental Hygiene.

nt; If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

burial-tran ed by the attending physician detached for use as the burla been signed by i should be detach

Division or Vital Records, P.O. Box 68760,

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within 24 hours after death To the Funeral Director;

State
Registrar

DHMH 17 Rev 1/2001

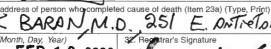
FEB 13

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifies



6 ☐ Could not be

determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 8

		1 = For State Registrar/Ameno#20b. Pen 1. Decedent's Name (First, Middle, La		Certificate of Death	Re	eg. No.		
Physic /Medi		SYDNEY O.	BARTLEY		2. Date of Deat Month FEB	Day Year 3. Time of De 9 2008 10:058		
Exami		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of E	Death	4c. County of Death		
Funeral Director		4021 72nd Ave 5. Social Security Number 217-92-5181	M OF		Hrs. 8. Date of Birth Min. (Month, Day,	Prince Georges 9. Birthplace (State or F. Country) 1926 Jamaica		
		Usual Residence of Decedent			NOV: 20	, 1920 Jamaica		
show	_	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City		
r 28a-f shov natified at	ecto	MD Prince G	Georges Landov	er Hills		1 _ Yes 2		
Die Die Die Die Die Die Die Die Die Die	급	10e. Street and Number		10f. Zip Code	10	og. Citizen of What Country?		
ns 23a	eral	4021 72nd Ave.	12. Was Decedent Ever in U.S.	20784	2 (Specify Ven or No	USA 14. Race - American Indian,		
r or reaun and Menial Hygene. If Item 27 is marked other than "natural", or Items 23a or or other traumatic event, if a Madical Examinar must be	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Nas Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P □ Yes 2 No Specify:	e (Specify 1 es of No- uerto Rican, etc.)	Black, White, etc. Specify: Black		
"natural", ulical Ext	etec	15. Decedent's Ed (Specify only highest gra	ducation 16a.	Decedent's Usual Occupation (Give kind of work done during most of	working	6b. Kind of Business/Industry		
in and Mental Hyglene. 7 Is marked other than "r traumatic event, I've Mad	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired) to Mechanic		Self Employed		
d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, N	faiden Sumame)		
Men	2	John Bartley			ner Ankle			
7 Is n traum		19a. Informant's Name/Relationship (Mailing Address (Street and Number o				
em 2		Kevin Bartley-Son 20a. Method of Disposition			owie, MD. 2	0 / 20 Oc. Location - City or Town, State		
Department of Health a Important: If Item 27 is any injury or other tra		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)	Cedar	Disposition (Name of remainder) responsition (Name of remainder) responsibilities Feb.	-15-2008 _	Suitland, MD.		
Important in suny in s	ji ja	21. Signature of Fundral Service Licer		hington, DC 20011				
ysician ledical aminer		Immediate Cause (Final disease or condition resulting in death)		ocarcinoma of Stom		st, Approximate Interval Betwe Onset and Dea		
physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
by the attending phy tached for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Yea		
signed d be de	by	Part II. Other significant conditions of		f tobacco use contribute to the cause of dea] Yes 2 □ No 3 □ Probably 4 ☑Unk				
page 2 shoul	Completed				24a. Was an autopsy perform	prior to completion of caus		
certificate rector, pag	Be	25. Was case referred to medical examiner?	112-1)				
death. ictor: After this y the funeral dis	tlon; To	27. Manney of Death 1 ☑ Natural 5 ☐ Pending		in the second	g Home 5 Resider 28d. Describe how	ce 6 Other (Specify) v injury occurred		
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Stre City or Town,	ation (Street and Number or Rural Route Number or Town, State)			
- E 0		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	ysicien: To the best of my knowledge, iner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place of the death o	ace, and due to the cau	use(s) and manner as stated. ee and place, and due to the cause(s)		
he Funaral	edic	one)						
To the Funaral completely filled	Medical	one) 29b. Signature and title of certifier		29c. License number	296	d. Date signed (Month, Day, Year)		
To the Funaral Dirac completely filled in b	Medic	51107	Herry mo	120986	29	d. Date signed (Month, Day, Year)		

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Y	/Medio		4a. Facility Name (If not institution, give CHESTER RIVE 5. Social Security Number 6. S	R HOSPI	TAL (3E) (In yrs. last birth	day) If Under 1 Year If	cation of Death HESTERTO Under 24 Hrs. 8 Da	4	c. County of De	ath O I irthplace (State or Foreign
-	Director		215-26-6106 1 Usual Residence of Decedent 10a, State 10b, County	□M 2√2 F	77 Y	rs.	Hours Min. (M. 4			MD 10d. Inside City Limits
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified, at	Director	MD KENT 10e. Street and Number		• •	TERTOWN		10g. C	Citizen of What (1 ☐ Yes 🎢 No
	death with	Funeral D	9075 Fairlee l	12. Was Decedent E		21620 13. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specify Ye	es or No-	USA 14. Race - An Black, Wh	nerican Indian,
9000	hours after tural", or its al Examine	<u>اچ</u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1 □ Yes 2 No S	Specify:		Specify BL.	ACK
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5- 4		lecedent's Usual Occupatio Give kind of work done duril ife. DO NOT use retired) TEACHER	n ng most of working	ĺ	Kind of Busines ${ m EDUCAT}($	•
yland ;	ges 1 and 2 should be filed t of Health and Mental Hygi If item 27 is marked other or other traumatic event, ti	To Be C	17. Father's Name (First, Middle, Last) GEORGE RINGGOLI				. Mother's Name <i>(First,</i> ULA ELIAS	Middle, Maide		
	and 2 sho lealth and I m 27 is ma her trauma	. 3	19a. Informant's Name/Relationship (7 KIM SMITH-DAU) 20a. Method of Disposition		112	Mailing Address (Street and Hillsdale Disposition (Name of		ling,		164
Baltimore,	Pa T∷ F		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licen)	cemetery,	crematory or other place) ue1 U.M. 22. Name and Address o	02/16/0	8 Por	nona, l	MD
Ba	permit. Departm Importa any inju		23a, Par 1, Ent of the disease, or comp	Dications the caused	0026) the death. Do no	Service 82	21 W.St.	Annapo	olis,	MD 21401 Approximate Interval Between
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8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, it any, reading to finite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of					
P.O. Box 68	death certifii e attending p d for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	lelivery Day Year
	The law requires that the date has been signed by the bage 2 should be detached	Completed by Ph	Part II. Other significant conditions of				sc Dsi	1 ☐ Yes	2 □ No 3 📉	to the cause of death? Probably 4 Unknown
Division or Vital Records,	2 8 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2₺ No	Hospital: 1 ☐ Inpatien	2 17 EB/Outp	Other	1[3. Place of Death (Chec		prior t death lo 1 🗆 Ye	es 2 No
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day	28b. Tir Year) 28b. Tir Inji	ne of 28c. Injury at Work?	2 □ No 28f. Lo	escribe how inj	ury occurred	Rural Route Number,
	he Hospita n 24 hours he Funera pletely fille	Medical C			examination and/	death occurred at the time, or investigation, in my opini				
)	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier			29c. License nu			ate signed (Mo	nth, Day, Year)
	6		30. Name and address of person who of the local day of th	ompleted cause of de i 00 i 00 i 00 i 00 i 00 i 00 i 00 i	Brown	St. Chosto	utown MI	2162	0	
DH	Sta Registr MH 17 Bev 1/20	ar		5 2008	less 1	t foot				

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	Physici /Medio		Larmella Kikoweki 10 2000										8:00p M
9	Examir		10000										
			Genesis	La Plata	a Center			La Pla	ta			Charles	
	Funeral Director		5. Social Security Nur 579–34–16		ex 7 □M 2 🔏 F	. Age (In yrs. las 78	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 20	Year)	9. Birthp Coun Wash	lace (State or Foreign stry) ington DC
	D *		Usual Residence of D	Decedent 10b. County		10c. City, 1	Fown or Lo	cation				1	Od. Inside City Limits
	Aaryta • ho	ō	MD										1 Yes 2 □ No
	the the table	ect	10e. Street and Numb	Charl	.es		La P1	10f. Zip Code			10a. Citiz	en of What Coun	itry?
	3a or	<u> </u>	258 Willi		Circle			20646			-	SA.	,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or items 23a or 28a-1 ehow important: if item 27 ie marked other then "naturel", or items 23a or 28a-1 ehow appring rough of the traumatic event, the Medical Examples roughed at ances.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	d 2 Married	T	2 Mo No		Was Decedent of H if Yes, specify Cuba I ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	1	4. Race - Americ Black, White, Specify: Whi	etc.
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Baltimore, Maryland 21215-0036	permit. Departrimporta eny inju		21. Signature of Fund	aral Service Licer	Schull	0945	22 F	REHART-E	CHOLS' FUI	NERAL HO	ME,P	.A.	
			23a. Part1. Enter the	disease, or com	plications that car	used the death.	Do not ent	211 St. M er the mode of dyin	ary's Ave ig, such as cardiac	or respiratory ari	est,	MD 2064	Approximate
	Physician		Immediate Cause (Fi	-	one cause on ea	ACIL	10	Renal	fail	010			Onset and Death
	/Medical		resulting in death)	-	a Due to (o	r as a consequer	nce of):	_					Days
ı	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)										weeks
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rds	quires n sign	d by	hy	perten.	sidn,	diab.	etes	mell	1165	1 🗆 Y	es 2□	No 3□Prob	ably 4 Unknown
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Ē	After t		27. Manner of Death 1 Natural	5 Pending	28a. Date of (Month)	Injury 28 Day Year)	Bb. Time of Injury	28c. Injun Work		28d. Describe h	ow injury	occurred	
Siol	tend death tor: /	cati	2 ☐ Accident 3 ☐ Suicide	investigation		M 1 Yes 2 No							
\leq	after of Direction by	Certification:	4 Homicide	determined	28e. Place o				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the within 2 To the complet	Me	29b. Signature and tit	le of certifier				29c. License	e number	2	9d. Date	signed (Month, I	Day, Year)
	> = 0		•		ndle"			Doc	06/6/4	4	Feb	ruany	11,2008
<	XRIN		30. Name and address	s of person who	completed cause	of death (Item 23	Ba) (Type,	Print) R-	SINDHU	JAN'			
	Sta	te	31. Date filed (Month,	Day, Year)	32. R	gistrar's Signature	9	W40/1	1 /01-	D .			
	Registr			EB 1 1	2008	new B	A. A.	Print) R. A. d. O. T. T. Devils					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 11, 2008 3:05 a M Ethelene G. Blair 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health&Rehab Glen Burnie Anne Arundel 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday /ear | It Union Days Min 8/7/1911 (ear) 216-24-2006 1 □ M 2 🗙 F 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No none Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3807 Pascal Ave 21226 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Wildowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aid Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Minear <u>Jeanetta</u> Beckner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willis R. Wright/son 3807 Pascal Ave. Baltimore, Md. 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBuria! 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/15/2008 | Glen_Burnie, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Driogra

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, the

Physician

/Medical

Examiner

10a. State

Md.

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-trar attending physician signed by the a within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

	resulting in death)	a. Due to (or as ons o	S / / V C	Teal 1	allarc	2 xears					
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										
ed by Ph	Part II. Other significant conditions o	contributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?					
Complet					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑No					
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
To E	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	6 □Other (Specify)								
ation:]	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju						
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factor	y, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)					
Medical Certification:	29a. Certifier 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigatio	d at the time, date and place, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an) and manner as stated. d place, and due to the cause(s)					
Me	29h Signature and title of certifier		29	c. License number	29d Da	te signed (Month Day Vear)					

uning for Aux. Balfo, ald 21226

(D)

To the Hospital or Attending Physician:

death.

State Registrar

29b. Signature and title of certifie

31. Date filed (M

M.D. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb 10,2008 Santa Wasson Blake 4:12a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 84 1^(M)0^h3^D/^y1 ^y9²2 4 Alabama 421-22-2579 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MDMontgomery Kensington 1XiYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be reason. 3616 Littledale Rd #106 20895 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Wasson Mabel Wilkin son 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Blake/Son Woodlawn Rd. Silver Spring, Md 20 310 8820 Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Elmwood Cemetery 2 /14 /2 008 Birmingham, Alabama 4 ☐ Donation 5 Other (Specify) Funeral Service License PATETPADESSATATION FUNERAL SERVI CE P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the Jease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Immediate Cause (Final Physician Cardiac arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary artery disease Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hypertension attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> lung cancer 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an hypernephroma autopsy osteoporosis 2 **X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending 5 ☐ Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D53691 Feb. 12,2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Redy MD 1500 Forest Glen Rd. Silver Spring,Md 20910 31. Date filed (Monte, Pay,

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

2008

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23a. Part. Emilis the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock of heart failure. Use only one cause on each line. Prevamonia a. Prevamonia 2 days Prevamonia bue to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due t	_	Har H	1							10d. Inside City Limits
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Tay, leading to immediate cause. Enter Underlying Course, (Lineases of Injury Course) Testilling in death) Last		Conventially list conditions								
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Dementia, Anemia 1 Yes 2 No 3 Probably 4 Unknow	hysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live birth 2 4 ☐ Pregnant at ti	Fetal death				23		
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27. Manner of Death 1 X Natural 2 Accident 3 Sulcide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 28d.	e C	avaminar?	Hospital: 1 Inpatient	2 ER/Outpat	ent 3 DOA Oth	er: 4 Nursing	Home 5 🗆 Res	idence 6	Other (Spec	ify)
29a. Certifier (Check only one) 29b. Signature and the of certifier (Speck only one) 29b. Signature and the of certifier (Speck only one) 29c. License number (Month, Day, Year) 29d. Date signed (Month, Day, Year)	o Be C			28b. Time	of 28c. Injury Work	y at k?				
29a. Certifier (Check only one) 29b. Signature and the of certifier 29b. Signature and the of certifier 29b. Signature and the of certifier 29c. License number D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ravi Passi, MD 15225 Shady Grove Road, #208, Rockville, MD 20850	on: To Be C	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	(Month, Day	rear) injun	M					ral Pouto Number
29b. Signatury and the of certifier D28656 D28656 D28656 Tebruary 11, 2008 30. Name and address gf person who completed cause of death (Item 23a) (Type, Print) Dr. Ravi Passi, MD 15225 Shady Grove Road, #208, Rockville, MD 20850	on: To Be C	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	(Month, Day)	y - At home, farm,					Number or Ru	al Houle Number,
Dr. Ravi Passi, MD 15225 Shady Grove Road, #208, Rockville, MD 20850	Certification: To Be C	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no 4 Homicide	(Month, Day) tion t be ed 28e. Place of Injurbuilding, etc. Physician: To the best of caminer: On the basis of e	y - At home, farm, (Specify) my knowledge, de xamination and/or	street, factory, office		City or To	own, State) cause(s) a	and manner as	stated.
Co. D. W. of Marth. Day Veryl	edicai Certification: To Be C	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	(Month, Day) tion t be ed 28e. Place of Injurbuilding, etc. Physician: To the best of caminer: On the basis of e	y - At home, farm, (Specify) my knowledge, de xamination and/or	ath occurred at the fininvestigation, in my o	pinion, death occ e number	City or To	e cause(s) a date and p	and manner as place, and due signed (Month	stated. to the cause(s)
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3 Time of Death Year **Physician** 11, FEB. 2008 Jamillah Abdul-Baaqiy 11:00 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3003 La Dova Way 8. Date of Birth (Month, Day, Year) Prince George's Springdale If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours 1□M 2XF Yrs. Director 150-54-0229 43 New Jersey Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Manyland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28e-f show any Injury or other traumatic event, I'm Mindical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3003 La Dova Way United States Funeral 20774 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Unknown Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Labor and Employee Relations Finance 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sakina Stewart Yahya Bashir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 30.03 La Dova Way
Springdale, MD 20774

20b. Place of Disposition (Name of cemetery, crematory or other place) Saddiq Abdul-Baaqiy, Husband 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State FEB. 12, Maryland National 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park
22 Name and Address of Facility Laurel, Maryland 2008 21. Signature of Funeral Service Licensee Thibadeau Mortuary Service, P.A. me M01508 933 Gist Ave., LL, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Breast Cancer Examiner Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ata has been signed by the ettending physician and paga 2 should be detached for use es the burial-trar Due to (or as a consequence of) by Physician/Medical Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed aX Nu 1 ☐ Yes 2 No 1 Yes r: After this certificative funaral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 TYes 2 TNo 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier H66665 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9200 Basil Court - Upper Marlhons, MD 20274 Dona 31. Dete filed (Month, Day, Year) FEB 12 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

2008

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Importent: If item 27 is marked oth
any injury or other treumatic event **Physician** /Medical **Examiner** Examiner Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funeral

þ

Completed

Be

r than "natural", or items 23a or 28a-f shov the Mastical Expruirer must be notified at

filed within 72 hours after death

Hygiene.

other

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

anding physician and use as the burial-transit The law requires that the death certificate be executed ó detached page 2 should be been has certificate or Attending Physicien: After death. the f within 24 hours after deat in by t pelli Hospital To the I

Completed by

Be

Certification: To

Medical

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Momicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

5 Pending investigation

6 Could not be determined

Zeya MD 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Carroll

ORIGINAL

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

, Takoma Parle, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per verb., 8876,02/26/08dhb Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 15,2008 **Physician** LILIAN ELIZABETH BOUGHTON 10:50 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** COUNTRY HOUSE CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Dav. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 15,1913 Months Hours Days Min 1 □ M 2(XF 212-38-5632 94 MAY MARYLAND Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits show 10b. County r 28a-f show notified at 1 ☐ Yes 2☐ No Director MD ALLEGANY LAVALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 229 NATIONAL HIGHWAY 21502 U.S.A. death \ Funeral 14. Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🗓 No Specify þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed than "natur he Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. the TEACHER **EDUCATION** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 ORBLE BROOKS BOUGHTON CHRISTINE MCALPINE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. 225 NATIONAL HWY., LAVALE, MD FRIEND 21502 JUANITA S. FIX 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State FROSTBURG MEMORIAL PK FEB 19 08 FROSTBURG, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. HAFER TUNERAL SERVICE, 1302 NATIONAL HIGHWAY, LAVALE, MD 21502 23a. Part1 Enter the disease on complications that caused the sait. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is vonly one cause by ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Oder, **Physician** amonte /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☑ No ed by the a 9☐Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy autops, performed certificate Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \(\text{Nursing Hame} \) \(\frac{520 \text{Re}}{500} \) Nesidence \(6 \) \(\text{Other} \) (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To O Living 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation Within 24 hours after community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Eccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and alle of certifier

State Registrar and address of pers

2008

31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

Sohon

D- Cumberland MD 7/302

se of death (Item 23a) (Type, Print)

Registrar's Signature

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- 1	Physici	an	1. Decedent's Name (First, Middle, Last) John Beauclas	re Brunson	1				Date of Deat Month BRUARY	Day	Year 2008	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give s		4b	. City, Town, or		Death	DNASINI	_	y of Death	
		*	Union Memorial			Baltime Under 1 Year	ore C	-	Date of Birth		T O Dinh	place (Chata as Familia
10	Funeral Director		5. Social Security Number 6. Sex 112	7. Age (<i>In yr</i> s. M 2□F 66		onths Days	Hours	Min	(Month, Day, eb. 16,	^{Year)} 1942	Cou	place (State or Foreign ntry) Virginia
-	pui »		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity. Town or Location	on						10d. Inside City Limits
	Maryla f shor	ror	MD 100. County		Baltimo							1 X Yes 2 □ No
	th the or 28a	Direc	10e. Street and Number			0f. Zip Code			10	og. Citizen of		intry?
	ath wi s 23a nust b	Funeral Director	3939 Roland Av		10 40 100	21211	lenenie Origi	i=2 (Cnooif	Voc or No		S.A.	can Indian,
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show Imatic event, the Medical Examiner must be notified at	Ď	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ※ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of Hi s, specify Cuba Yes 2 XNo	Specify:	Puerto Ric	an, etc.)	Bla	ick, White,	, etc.
5-0	"natur	eted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Decedent	s Usual Occupa of work done of NOT use retired	ation during most	of working		16b. Kind of E	Business/Ir	ndustry
121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		tricia				Maint	enar	nce
nd	al Hyg d other	Be C	17. Father's Name (First, Middle, Last)						irst, Middle, N			
ry Ia	d Mend barked	P	John B. Brunso 19a. Informant's Name/Relationship (Ty)		19b. Mailing Ad	drose (Street			Ruth			in Code)
Ma	nd 2 sl allth and 27 is r r traur		Charlene Sciarre			akesid						
ore,	es 1 and 2 should be filed within 72 ho of Heath and Mental Hygiene. I flem 27 is marked other than "natul r other traumatic event, the Medical		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 💆 R	20b.	Place of Dispositio cemetery, cremato Cremata	n (Name of		eb. 19	9	20c. Location	- City or T	own, State
Baltimore, Maryland 21215-0036	t. Pages tment of I tant: If ite		4 ☐ Donation 5 ☐ Other (Specify)	Di	irect Se	ervice		2008	,			17401
Bal	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	Meur	24	Second	St.,	New	Freed	om, P.		tuary, Inc. 349
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	ie Hospii 124 hour ie Funera letely fille	Medical (sician: To the best of my kn ner: On the basis of examin and manner stated.								
_	To th withir To th comp	Me	29b. Signature and title of certifier	м	D	29c. Licens				9d. Date sign		
	0		M. Non-kn			AT-	4438	446		CISKIDA	۲۹,۱	6,2008
	3		30. Name and address of person who co Dr. R. RANGANATH	UNION	MEMORIA	- hosp	ITAL,		BALTI	MORE,	MS).
- 1	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 6 2008	32. Registrar's Figr	natur							

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Shock or heart failure. List only one cause on each line. Infered Bet Cause (Final disease or condition resulting in death) Physician / Medical Examiner Page 12	e a m m e		Klee	1 X	uaa	m	5	4 (04 Decat	ur Stree	t, Cumb	erlar	nd, MD	21502	
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ospit hours unera		29a. Certifier	ertifying P	hysiclan: To th	e best of r	ny knowledge	e, death	occurred at the til	me, date and place	e, and due to the	e cause(s) and manner a	s stated.	e(s)
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17565 February 11, 200	To To com	2	29b. Signature and title of	certifier	7 01										
3	3			AB-	yeu-							re	y	11, 20	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1000									Highway	, LaVal	e, MD	21502	2	
2 MD 21502	1100														
	State	е	31. Date filed (Worth, Day,	Year)	32	Registrar's	Signature	An	acht s						

Physici: :/Medic	an	State Registrar #26, per phys., 1. Decedent's Name (First, Middle, Last) LULA MARINER					2. Date of De Month	Day Year	3. Time of Death
4	al		BRADFORD		4h City Town	a Longtina of Doot	FEB	8 200	
Examin	er	4a. Facility Name (If not institution, give street 9440 WHALEYVILLE RO.			WHALEY	r Location of Deat VILLE	n	WORCES'	
uneral rector		5. Social Security Number 6. Sex 222-03-0684 1 □ M		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	1, 1911 Di	rthplace (State or Foreigr country) ELAWARE
MO III		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
a-f-e-	ctor	MARYLAND WORCESTER	W	HALEYVI	LLE				1 ☐ Yes 2X No
or 28	Director	10e. Street and Number 9324 WHALEYVILLE ROA	D		10f. Zip Code 218	7 0		10g. Citizen of What C	country?
ns 23	Funerai	11. Marital Status 12. W	/as Decedent Ever in I	J.S. 13. V		lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No		erican Indian,
rel', or iter Eraciper		1 Never Married 2 Married 1	med Forces? ☐ Yes 2 📉 No Yes, Give ear or Dates:		fYes, specify Cub 1 □ Yes 21√2 No		o Rican, etc.)		ite, etc. WHITE
ed other than "naturel", or Items 23s or 28s-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retired E WORKER	during most of wor d)	rking	16b. Kind of Business	s/industry
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ie marked aumatic ev	To B	GEORGE WELLS				MINNIE 1	BELLE (M	AIDEN NAME	UNKNOWN)
raum raum		19a. Informant's Name/Relationship (Type, PPEGGY WILES / DAUGHT)	•		-			er, City or Town, State,	
tem 2		20a. Method of Disposition	1 1	Place of Dispo	sition (Name of	-	Date Date	VILLE, MD 2	
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important: if Item 27 ie marke eny injury or other traumatic once.		21. Signatore of Funeral Service Ligensee	12	22 W	Name and Addre	ss of Facility NERAL HON	1E	LLSBORO, DI	
edical miner transit	lical Examiner	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	TIS queries of):	Polyald	W			Interval Between Onset and Death
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or, page	Be	examiner? 1 ☐ Yes 2 No Hospit	al: 1 ☐ Inpatient 2 [] ER/Outpatien	t_3□DOA	er: 4 🗆 Nursing H		dence 6 🙀 Other (Sp	Residence
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octor: Alter this by the funeral d	Certification; To	1 Natural 5 Pending 2 Accident Investigation	e. Place of Injury - At I building, etc. (Spec	nome, farm, str	M 1 🗆		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
the Funerel Director: After this certificate has be pletely filled in by the funeral director, page 2 s	Certification;	1 Natural 2 Accident 3 Surcide 4 Homicide 29a. Certifier (Check only one) 1 Natural 5 Pending investigation 6 Could not be determined 28 28 29a. Certifier (Check only one)	e. Place of Injury - At I building, etc. (Spec	nome, farm, straity)	M 1	Yes 2 □ No	City or To	wn, State) cause(s) and manner a date and place, and du	as stated. se to the cause(s)
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		-	For State of Maryland		rtment of He tificate of D			ene g. No. 🤈 🗎 🦳 📿	nsons
	Dhysicia	_	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic	al .	Barbara D. Barnett		4b. City, Town, or	Location of Death	rebruary	4c. County of Death	5:15P₩
	Examin	er	4a. Facility Name (If not institution, give street and number) 11707 Pine Street		Beltsv			Prince G	_
2.	Funeral Director		5. Social Security Number 6. Sex 1 M 2/3 F 7. Age (In yrs. Ia 77)	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 12,	1930 Mary	place (State or Foreign intry) Land
	Maryland -f show fied at	tor	rou. ctate	Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 📉 No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 11707 Pine Street		10f. Zip Code 20705		10	og. Citizen of What Cou United Sta	ites
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mertal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Was Decedent Ever in U.S Armed Forces? 1 □ Yes A □ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2XÑo	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	n 72 ho '"natur ledical I	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired	ation luring most of work)	ing	16b. Kind of Business/I	ndustry
212	d within giene.	Somp	Elementary/Secondary (0-12) College (1-4or 5+)		employed			General Cor	ntractor
and	the filed and the filed set of the filed	Be	17. Father's Name (<i>First, Middle, Last)</i> Michael Morris Dillon			18. Mother's Nam Irene Ver			
Maryland	nd 2 should I lith and Meni 27 is marked r traumatic e	To	19a. Informant's Name/Relationship (Type. Print) Patricia A. Fisher -daughter					City or Town, State, 2 Maryland 2	
Baltimore,	Pages 1 and 2 nent of Health int; If item 27 iry or other tra				isition (Name of matory or other plac itan Crema	e) ¦		20c. Location - City or Alexandria,	
Balti	permit. Pages Department of Important: If i any Injury or once.	Į Į	21. Signature of Funeral Service Libensee	²² 1 44	Donald V. 400 Powde	Borgward Borgward Mill Ro	dt Funera oad Belts	al Home, PA sville, Mar	vland 20705
	Dhysisian	8 8	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		er the mode of dyin ert Failu:		or respiratory arre	est,	Approximate Interval Between Onset and Death 3 days
	Physician /Medical		resulting in death) Due to (or as a consequ	ence of):			D.'		<u> </u>
	Examiner	e.	Se gentially list conditions b.		tic Cardi	ovasculai	c Disease	9	
	ecuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of the cause). Due to (or as a consequence of the cause).	ence of					
68760,	icate be executed physician and the burial-transit	dical E	d.						
.O. Box 68	The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as in	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of del Month	livery Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resu Myelodysplastic Syndrome	lting in the u	inderlying cause giv	en in Part I.		bacco use contribute to es 2□No 3□Pi	o the cause of death?
or Vital Records,	. The law requir cate has been si page 2 should l	Completed					24a. Was a autops perfor 1∐ Yes	sy prior to	utopsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		et all DOA Oth		th (Check only on		
ō	Phys r this ral dir	-: 10	27. Magner of Death 28a. Date of Injury	28b. Time of Injury	III 3 DOA	4 □ Nursing H		ence 6 Other (Spe ow injury occurred	ecify)
Division	Attender death ector:	Certification:	1 ⚠ Natural 5 ☐ Pending (Nontur, Day Year) 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 4 ☐ Homicide 28e. Place of injury - At ho building, etc. (Specif,	me, farm, st	M 1□	Yes 2 □ No	28f. Location (S. City or Town	treet and Number or R n, State)	ural Route Number,
ō	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examina	wledge, dea tion and/or in	th occurred at the ti	me, date and place	e, and due to the curred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	o the l	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
	10		, tho a	M.S	D247	21		February 8	8, 2008
			30. Name and address of person who completed cause of death (Item Syed A. Sadiq, M.D. 14333 Laure 31. Date filed (Month, Day, Year) 32. Pegistrar's Signa	1 Bow	ie Road,#	208 Laur	el, Mary	land 20708	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 1 2008 32. Pigistrar's Signa	B B	barte				

			partment of Health and N ertificate of Death		No.2 A A A	05006
Physicia	an	1. Decedent's Name (First, Middle, Last) Brenda Helayne Bingman		2. Date of Death Month February	Day Year 8, 2008	3 Time of Death 8:30a M
/Medic Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring		4c. County of Death	omery
Funeral Director		5. Social Security Number 142-32-4089 6. Sex 1 □ M 2 □ F		8. Date of Birth (Month, Day, Ye Dec. 2, 1	ear) 9. Birthp	lace (State or Foreign ttry) Jersey
0	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			1	0d. Inside City Limits 1
th with the N 23a or 28a-i ist be notifi	Funeral Director	10e. Street and Number 1902 Agate Drive	r Spring 10f. Zip Code 20904		Citizen of What Cour	
iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. And Hear 21 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🙀 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
within 72 hou ene. than "natura he Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king	D. Kind of Business/Inc	
should be filed w nd Mental Hygie marked other tl matic event, th	To Be Col	17. Father's Name (First, Middle, Last) Alfred Jones		e (First, Middle, Mai e Glasser	DC Governiden Surname)	iment
and 2 shou salth and M n 27 is mar er traumat		Stacey A. Flynn/Daughter	iling Address (Street and Number or Ru 10106 Church	Hill Road	, Myersvil	lle, MD 217
permit. Pages 1. Department of He Important: If Iten any injury or oth		**Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Parklaw**	1	0. 11,	Rockville,	
permit Depar Impor any ir		21. Signatu on Funeral Service Licensee 23a. Part1. Enter the disease, or comblications that caused the death. Do not shock, or heart failure. List only one cause on each line.	Francis J. Collins 500 University Blv	/d, W., Si	lver Sprir	Approximate
Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Fails Due to (or as a consequence of):				Interval Between Onset and Death Month
ficate be executed was physician and street burial-transit	al Examiner	Sequentially list conditions, if any, leading to immiscrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Primary Peritonea c	l Carcinoma			2 Months
eath certi attending for use a	Physician/Medical		3 ⊟Ectopic pregnancy 5 □ Other (specify)	_	23d, Date of deliv Month	ery Day Year
quires that the de n signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	
	Completed			24a. Was an autopsy performe 1∐ Yes 2 ∑	d? death?	opsy findings available ompletion of cause of 2 ☐ No
ding Physician; T n. After this certificat funeral director, pa	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 21 No 27. Manner of Death 11 Natural 5 ☐ Pending (Month, Day Year)	ient 3 DOA Other: 4 Nursing F	ath Check onl one dome 5 ☐ Residence 28d. Describe how	ce 6 Other (Speci injury occurred	ity)
r Attention designation of the the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
To the Hospital of within 24 hours aft of the Funeral Discompletely filled it	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d Description on the basis of examination and/of and manner stated.	eath occurred at the time, date and place rinvestigation, in my opinion, death occurred at License number	urred at the time, dat	ise(s) and manner as e and place, and due	to the cause(s)
with	2	29b. Signature and title of certifier 3 June and address of person who complished cause of death (Item 23a) (Ty	D35996	Fe	ebruary 8,	
C+	ate	Linda M. Burrell, MD 2730 Univ	ersity Blvd, #400,	Wheaton,	MD 20902	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10b per fh, g882, 08/07/08dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12 **Physician** Month February Brenda Kay Creek 2008 5:51 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 2XF Country) Mary Land 50 215-76-8211 Sept.12,1957 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at annea. 10b. County Frederick 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Middletown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7423 Picnic Woods Road 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Package Delivery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Edward Guthrie Creek J0sephine Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Shawn Turner – Husband</u> 7423 Picnic Woods Rd. Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory Feb.14,2008|Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Societe Vice OSBETTE TURNEL Fadity Home. P.A. Marille 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme to Cause (Final disea e or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner tastatiz if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1□Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending after death. 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D003516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Frederick, Md. 21701 32. Registrar's Signature Hee Myung 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

			1 - State o	•	artment of Health and I	Mental Hygier	2002	05908
	9		Decedent's Name (First, Middle, Last)			2. Date of Death	10- 0 0	3. Time of Death
	Physici		Charles Raymond Crawfor	d			Day Year	5:05 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or Location of Deat	Febuary	11,2008 4c. County of Dear	
1			Ravenwood Lutheran Vill	a0e	Hagerstown		Machin	~ # ~ · ·
	Funeral		Social Security Number	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Yea	Washin 9. Bir	hplace (State or Foreign
	Director		219-12-2495 ^{1\(\text{M}\) M 2\(\text{F}\)}	84 Yrs.	Months Days Hours Min.	Oct. 14,		aryland
	pun .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	option			101 1-11 00 11 0
	sho	,						10d. Inside City Limits 1 ☐ Yes 2X No
	the N 28e-1	Director	Maryland Washington 10e. Street and Number	l l	lagerstown	10-	Obligate of Markets O	
	with le or	Ö	1228 Frederick Street		10f. Zip Code 21740	1	Citizen of What Co JSA	ountry?
	ns 23	era		edent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (S		14. Race - Ame	nican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show early injury or other traumatic event, I're Madical Eventinal te naillised at once.	by Funerai	1 ☐ Never Married 2 【X Married Armed Fo	rces?	f Yes, specify Cuban, Mexican, Puerl 1 □ Yes 2⊠ No Specify:	o Rican, etc.)	Black, Whit	
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פר	e filed of the vent,	se C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid		
Maryland	ould b Menta	To B	Charles R. Crawford, Sr	•	Genevi	eve E. Ride	enour	
Mar	l 2 sh n and ls m reum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			
е, _	1 and 4ealth 3m 27 ther t		Margaret D. Crawford - w 20a. Method of Disposition		Frederick St., 1			
Baltimore,	ages nt of h : If ite		1 XBurial 2 ☐ Cremation 3 ☐ Removal from	State k	sition (Name of natory or other place)	1	Location - City or	
들	it. Partmen		 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 		en Cemetery 2/14 Name and Address of Facility			, Maryland
Ba	perm Depa impo eny i		Syllatile of Landing of the Literature of Landing of the Landing o			MINNICH F		
		-	23a. Part1. Enter the disease, or complications that of	aused the death. Do not ent	15 E. Wilson Blvd		own, Ma.	Approximate
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Вох	death certific e attending p d for use as	ian/	in the past 12 months?		Ectopic pregnancy		23d. Date of del Month	ivery Day Year
o.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Fregn 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			,
Д.	that the ded by detail	Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
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00	> 0 0	Completed	, -	•		24a. Was an	24b. Were au	utopsy findings available
Re	0 - 0	шо				autopsy performed	prior to death?	completion of cause of
Vital	iclen: Th certificate ector, pag	d)	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☑ I ath Check onlone	No 1 ☐ Yes	2 LI NO
f∨	Physiclen: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	npatient 2 ER/Outpatien	t 3 DOA Other: Nursing H	Iome 5 Residence	6 □Other (Spe	cify)
n of	iding Phys Ih. After this funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Date (Monitor)	of Injury 28b. Time of Injury		28d. Describe how in		
Sio	Attending r death. ector: After by the fune	cath	2 Accident investigation		M 1 Yes 2 No			
Division	n ite	Certification:	determined 286. Place	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,
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	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	Check only 2 Medical Examiner: On the ba	asis of examination and/or in- ner stated.	vestigation, in my opinion, death occu	rred at the time, date a	and place, and due	to the cause(s)
	To t To tl	×	29b. Signature and title of certifier		29c. License number		Date signed (Mont	h, Day, Year)
					D00623	27	2/12/0	В
Ä	1-241		30. Name and address of person who completed caus		Print) STOWN, MG	2170	10	
	Sta	te		pistrar's Signature	1	P 1	<u> </u>	
	Registr	ar .	FEB 1 3 2008		2366			

	Please Type or P State of State Registrar	Maryland / De		lealth and M	ental Hygie	ne	0500
hysician /Medical	1. Decedent's Name (First, Middle, Last) William Thomas	Culver, S			2. Date of Death Month	Day Year	3. Time of Death
Examiner uneral	4a. Facility Name (If not institution, give street and number Social Security Number 6. Sex 7. 1 M M 2 F	er) All POL LENT Age (In yrs. last birthda 68	ay) If Under 1 Year	Location of Death OUSCLE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Forei
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			10/17/19	39 Mar	10d. Inside City Limi
or 28a be notif	Maryland Wicomico 10e. Street and Number 910 Marble Court	Salisb	10f. Zip Code 21804	4	10g.	Citizen of What Co	1 X Yes 2 □ N ountry?
al", or items examiner mi	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	□No	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Spe In, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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arked oth atic event	17. Father's Name (First, Middle, Last) William James Culver				Sue Bowd	en	
m 27 is m ner traum	19a. Informant's Name/Relationship (Type. Print) Ruth C. Culver/wife	910	ailing Address (Street a	ourt, Sali	isbury, M	D 21804	
rtant: If iter njury or oth	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 1 □ Contact State 1 □ Con	ate cemetery, c	sposition (Name of crematory or other places Cemetery	2/12/	08 5	Location - City or Salisbury	, MD
an ir o	Signature of Funeral Service Licensee	_CFSP	Holloway 501 Snow				
ician dical miner	23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac immediate Cause (Final disease or condition resulting in death) Due to (or	as a consequence of):	enter the mode of dyin	g, such as cardiac o	rrespiratory arrest,		Approximate Interval Between Onset and Death
g physician and as the burial-transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
for use		h 2 □ Fetal death It at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
6 Pe	Part II. Other significant conditions contributing to deat	h but not resulting in the	e underlying cause give	en in Part I.	23e. Did tobac		o the cause of death? robably 4 Unkno
tor, page 2 should e Completed	obstructive sleep apor 25. Was case referred to medical	ea		26. Place of Death	24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause o c 2 No
Medical Certification: To Be Compl	examiner? 1	Injury 28b. Time Injury injury - At home, farm,	e of 28c. Injury Work M 1 1	er: 4 □ Nursing Hom vat 2 Yes 2 □ No	ne 5 Residence 28d. Describe how i	njury occurred t and Number or R	ural Route Number,
cal Certi	29a. Certifler (Check only 29 Medical Examiner: On the basi	, etc. (Specify) est of my knowledge, de	eath occurred at the tin	ne, date and place, a	City or Town, S	e(s) and manner a	s stated.
Medical Co	29b. Signature and title of Certifler	r stated.	29c. License			Date signed (Mont	
State		of death (Item 23a) (Type Peninsu istrar's Signature	la Regional	Medical (Center S.	Elisbury A	40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay Grace Cowger

4b. City, Town, or Location of Death

If Under 1 Year | If Under

Days

7. Age (In yrs. last birthday,

10c. City, Town or Location

85

4c. County of Death

8. Date of Birth (Month, Day, Year)

11-3-1922

(comico

Maryland

Birthplace (State or Foreign Country)

10d. Inside City Limits

Physician /Medical Examiner

Marian

10a. State

5. Social Security Number

214-12-6358

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

6. Sex

1□M 2XF

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the IM - ical Examiner must be notified at angle.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

io	MD Wicomi	20	Pitts	ville				1 ☐ Yes 2 No
Funeral Director	10e. Street and Number	-		10f. Zip	Code		10g. Citizen of What C	ountry?
<u>e</u>	7575 Perdue Stree	et			21850		USA	
iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Deced		? (Specify Yes or No Puerto Rican, etc.)		
3	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give)	1 ☐ Yes 2		25.10 7.102.1, 510.7		
Completed by	3	Year or Dates:					Specify: W	
ete	15. Decedent's (Specify only highest of	Education grade co <i>mpleted)</i>	16a.	Decedent's Usua (Give kind of work	k done dunna most o	f working	16b. Kind of Business	s/industry
d m	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use	,		_	
ပ္ပ	17. Father's Name (First, Middle, La	et)		Homemal		Name (First, Middle,	Own Home	
Be	Clifford Thirman	,						
၉	19a. Informant's Name/Relationship		10h	Mailing Address		n May Rua	rk er, City or Town, State,	7:- Codel
								Zip Code)
-	Charlotte V. Cros	well/Daught	er P.	O. Box I Disposition (Nam	54, Pitts	ville, MD	21850 20c. Location - City o	r Town State
	1 X Burial 2 ☐ Cremation 3		cemeter	y, crematory or ot	her place)			
-	4 Donation 5 Other (Spec		Springh	nill Memo	ry Gds	2-14-2008	Hebron, Ma	ryland
	21. Signature of Funeral Service Lic	ensee					ıneral Home	
\dashv	23a. Part1. Enter the disease, or co	malications that sourced to	no dooth Doo	1/05 E.	Main Stre	et, Salish	oury, Maryl	and 21804 Approximate
	shock, or heart failure. List on	ly one cause on each line					rrest,	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	d			MORRHA	THE.		
	resulting in death)	Due to (or as a	·	,				
_	Sequentially list conditions, if any, leading to immediate	b. HYPERT						
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	of):				
хал	that initiated events resulting in death) Last	c Due to (or as a	000000000000000000000000000000000000000	nf\.				
Ē		Due to (or as a	consequence c	л).				
dic		d						
Be Completed by Physician/Medical Examiner	IF FEMALE:	23c. If yes, outcome pr	nregnancy					
ian	23b. Was decedent pregnant in the past 12 pronths?	1 ☐ Live birth 2	Fetal death	3 ☐ Ectopic pre			23d. Date of de Month	Day Year
ysic	1 ☐ Yes 2 2 ☐ No 9 ☐ Unknown	9☐Unknown	ine or death	5 □ Other (spe	-cny)			
됩	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying ca	use given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
9						10	Yes 2□No 3□F	Probably 4 Utnknown
ete								
d l						— 24a. Was		utopsy findings available completion of cause of
8						1□ Yes	2 → No 1 → Ye	s 2□No
	25. Was case referred to medical examiner?	Hospital:				Death (Check only o		
유	1 ☐ Yes 2 ☐ No 27. Manper of Death	Hospital: 1 Inpatient					dence 6 □Other (Sp	ecify)
io iii	1 Natural 5 Pending	28a. Date of Injury (Month, Day			Bc. Injury at Work?		how injury occurred	
cat	2 Accident investigati 3 Suicide 6 Could not	be 290 Place of injur	. At home for	M otract factors	1 ☐ Yes 2 ☐ No		24	2 (Dayle Market
E	4 ☐ Homicide determine	28e. Place of injury building, etc.	(Specify)	m, street, factory,	опісе	City or Tou	Street and Number or F vn, State)	tural Houte Number,
ဒ္ဓ	29a. Certifier 1 Certifying I	Physician: To the best of	mytenoulodoo	death accurred	A Ale a time a state a sent	stage and due to the		
lica	(Check only one)	Physician: To the best of aminer: On the basis of e and manner state	examination and	d/or investigation,	in my opinion, death	occurred at the time,	date and place, and du	is stated. le to the cause(s)
Medical Certification:	29b. Signature and title of certifier	and manner state		29c	License number		29d. Date signed (Mor	oth Day Year)
_							and signing (1910)	
	► COX D. M.	D		1	7631123		DILLIR	, Duj, 10a./
	30. Name and address of person wh	D	W (I)		763433		02/U/B	

State

Registrar

31. Date filed (Month, Day, Year)

FEB 13 2008

32. Registrar's Signature

Rebecca Frances	1	- For State	laryland / I	Departme <i>Certifica</i>		Health and <i>Death</i>	Mental		g. No. 2 (108 0591
Physicia	n/	1. Decedent's Name (First, Middle,Last)						Date of Deat Month		3. Time of Death
Medical Examin	er	Rebecca Frances	Cole					February 1	8, 2008	1237 hrs
		4a. Facility Name (If not institution, give stree 6121 Middleburg Road	t and number)		41	c. City, Town, or L Keymar			4c. County of E Carroll	Death
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birth	day)	If Under 1 Year		Hrs. 8. Date of Birt	F	Birthplace (State or oreign Manager 1
Director		215-82-2504 1 m s	X F	47	Yrs.	Months Days	Hours	Sept 2	7, 1960	oreign Maryland Country
>	Ē	Usual Residence of Decedent 10a. State 10b. County	Tar	Dc. City, Town o	or Locatio	n				10d. Inside City Limits
ow any		Maryland Carroll	["	oo. Gity, 10Wil (, LUCANO		Keymar			1 Yes 2 No
Maryland 28a-f show d at once.	흱	10e. Street and Number			Т	10f. Zip Code		110	ng. Citizen of What	
는 를 하고 한 <u>기</u>	l Director	6121 Middleburg Road	Ē				21757		USA	
th wir	era		Vas Decedent Ev rmed Forces?	ver in U.S.	13. Was	Decedent of Hisp s, specify Cuban,	oanic Origin? Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - A White, 6	American Indian, Black, etc.
er dea	Funeral	3 Widowed 4 Divorced If Yes,	Yes 2	No No	1 .	Yes 2 X No	specify:		Specify:	white
urs aft urat"	ᅀ	15. Decedent's Education (Specify only high	es:	leted) 16a. I	Decedent'	s Usual Occupation	on (Give kind	of work done	16b. Kind of Busin	ness/Industry
72 hou	Completed		ollege (1-4 or 5+		luring mo	st of working life.	DO NOT use	retired)		
5-0036 led within 7 tygiene. other than the Medica	d E	12			Ho	memaker				Home
15-0 Tiled w Hygid Jothe the h		17. Father's Name (First, Middle, Last) Frank Zukowski				1		ame (First, Middle, I	Maiden Surname)	
21215-0036 hould be filed within 7 nd Mental Hygiene. is marked other than nife event, the Medica	Be	19a. Informant's Name/Relationship (Type, P	rint)	196	. Mailing	Address (Street		e Lefler	nber, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", con other traumatic event, the Medical Examiner.	۵[David A. Cole, husba		6	5121	Middleb	urg Roa	ad, Keyma	r, MD 217	57
ore, MC is land 2 s of Health au If item 27		20a. Method of Disposition 1 Neurial 2 Cremation 3 Re	moval from State		f Disposit ory or othe	tion (Name of cen er place)	ŀ	Date		ity or Town, State
Pages nent of ant: I		4 Donation 5 Other Specify:	movar nom State	-	e UCC	Cemete		2/23/2008		own, MD
Baltimore, permit Pages I an Department of He Important: If ite	_	2 Signature of Funeral Service Licenses			22. Na	eme and Address E. Balt	of Facility N	Myers-Dur Street,	boraw Fur Taneytowr	neral Home n, MD 21787
Physician	\forall	23a. Part I. Enter the disease, or complication	ns that caused th	ne death. Do no				•		•
/Medical	7	Mailure. List only one cause on each line Immediate Cause (Final disease a. Fen	tanyl into	oxication	ı					Death
vaminer			(or as a conseq							
	إي	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a conseq	uence of):						
	틸	cause. Enter Underlying Cause								
uted nd ransit	l Examine	events resulting in death) Last Due to	(or as a conseq	uence of):						
60, e be executed ysician and burial - transit	edical	☐ ¥M	NDED 7 282	-f perMF	. 0877	3/6/08 T				
760, cate be	Me	IF FEMALE: 230 23b. Was decedent pregnant in the	. If yes, outcome	of pregnancy		_ [elivery
68 certifi nding ise as	sician/M	past 12 months?	Live birth Pregnant at ti	me of death 5		al death 3 [ner (Specify)	Ectopic pre	egnancy	Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the l	ysic	1 Yes 2 No 9 ✓ Unknown g	Unknown		Otn	ier (Specify)				
O. – nat the sid by the etacher	y Phy	Part II. Other significant conditions contr	ibuting to death	but not resulting	j in the u	nderlying cause g	iven in Part I.			ute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. 'al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ed by									Probably 4 Unknown
ords w requ	plete	J						24a. Was	osy pri	ere autopsy findings available for to completion of cause of
Rec(The larate ha	Completed									eath? Yes 2 No
tal F	Be C	25. Was case referred to medical examiner?					of Death (Ch			
Physic rthis aldire	2	1 ✓ Yes 2 No	I IIIpatieii		utpatient Time of Ir				Residence 6	
n ol ding I ding I After funer		1 Natural 5 Dending	8a. Date of Injury (Month, Day,Yea	ar)		10	ryat Work? Yes 2 χ No		now injury occurre	-
SiO	cati	2 Accident Investigation	Fnd_2/18/2		12:2	5 pm			Street and Number	or Rural Route Number, City
Divi	Certification:	3 Suicide 6 X Could not be	(0/5-)	und at ho				or Town.		
	Medical C	29a. Certifier 1 Certifying Physician: T (Check only one) 2 Medical Examiner:On the	o the best of my ne basis of exam	knowledge, dea	ath occur	red at the time, da	ate and place,	and due to the cau	se(s) and manner a	as stated.
To with	Med	29b. Signature and title of certifier	manner stated.			29c. Licens				d (Month, Day, Year)
WST		Doma moineat	IMD.			O.C.I	M.E.		February 19	, 2008
0		30. Name and address of person who compliance Donna M. Vincenti, MD Assi	eted cause of de stant Medica		111	Penn Street,	, Baltimore	, MD 21201	-	
Sta	ate	31. Date filed (Month.: Day, Year)	32. Registrar'			,				
Regist		FEB 2.0 2008	Stere	w St.	do	ante				
DHMH 17 Rev 1/20	101	00		OR	IGINA	L				

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month.

12 EG.

Bonita Krempel-Portier, D.O. 121-123 W. Main St., rear Emmittsburg, MD 21727

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. ^{Day} 2008^{Year} **Physician** JESSIE 9, MAE CROME 6:55P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Angel Garden Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. July25, 1 Country) SC 1 M 2 F 247-52-0421 83 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 5024 Norbeck Road 20853 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: Black altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 💥 No Specify. ģ 3 Widowed 4 □ Divorced Completed the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Postal Service ith and Mental Hygid 27 Is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Louis Wirght Mary L. Anderson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trainonce. Reginald Crome - Son 5024 Norbeck Rd Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 ☐Removal from State Park Nawn Mem 2/14/08 Rockville, MD 22. Name and Address of Facility Snowden Funeral Rome, PA 21. Signature of Funeral Service Lich 246 N. Washington ST Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician ADVANCED DEMENTIA (SDAH) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for as a nonsectionne offi-Examiner if any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 NUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has al director, page 2 autopsy perform 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phythin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 13 2008

Génevieve Wroblewski, MD 1355 Piccard Drive Rockville, MD 20850 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D64615 29d. Date signed (Month, Day, Year)

Feb. 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Пау Physician Рм 2008 4:40 6 Feb. Rhea Robinson Claggett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maplewood Park Place Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct. 9, 19 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🖺 F 578-62-2087 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f sh notified a 1 ☐ Yes 2 No Director MD Montgomery Bethesda the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.
Intel flem 27 is marked other than "natural", or items 23a or 3 and 17 is marked other than "natural", or other traumatic event, the Medical Examiner must be not 9707 Old Georgetown Road #2209 20814 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No White Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irving E. Robinson Augusta Haubrich ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mariamne Vickery/Daughter 9408 Wildoak Drive, Bethesda, MD 20814 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pages 1
Department of H
Important: If Ite
any Injury or ot Arlington National Eemetery 1 X Burial 2 ☐ Cremation 3 X Removal from State Marsh₈7 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License RACI 10 East Deer Park Drive, Gaithersburg, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** End Stage Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease physician and sthe burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2XNo 3 Probably 4 Unknown <u>Congestive Heart Failure</u> Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy performed his certificate I 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ပို this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

DHMH 17 Rev 1/2001

State

12 FEB Registrar

29b. Signature and title of certifler

Merlyn K. Vemu: 31. Date filed (Month, Day, Year)

9801 Georgia Ave. #227, Silver Spring, Maryland 20902 M.D 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vemury,

29c. License number

D35791

29d. Date signed (Month, Day, Year)

February 7, 2008

			For State	State of Mar	yland					lental Hy	giene)		g year
			For State Registrar			Cer	titicat	e of L	Death	2. Date of De	Reg. No	2008	3. Time of D) beath
i na	Physicia	an	1. Decedent's Name (First, Middle, Las Mary Claire Celt	/ /						Month Februa:	Da	o, 2008	11:45	
	/Medic Examin	k Wat	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of Death	Tebi ua.		County of Deat		73
	Examin		Suburban Hospital	1			Bet	hesd	la			ntgomer	У	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. las	st birthday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 03/22/	th y, Year)	9. Birt Co Can	hplace (State or untry)	Foreign
,	Director		691-07-2055	LIW ZMF	71	Yrs.				03/22/	1936	Can	ada ———	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City	Limits
	Mary a-f sh	tor	MD Montgome	ry	Poto	mac							1 ² ∕∑Yes 2	2 🗌 No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 7844 Heatherton L	ane			10f. Zip 208	Code 354			10g. Cit Cana	tizen of What Co ada	untry?	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:)		1 □ Yes	2 [No	ispanic Origin? (Span, Mexican, Puerto Specify:			14. Race - Ame Black, White Specify: Wh	e, etc. ite	
7-	"natu	ete	15. Decedent's Ed (Specify only highest gra	lucation ide completed)		16a. Deced	tent's Usu kind of wo	al Occup ork done i	ation during most of work f)	ing	16b. K	(ind of Business/	Industry	
121	within ene. than be Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	Admin	istr	ativ	g Support		Car	nadian E	mbassy	
d 2	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	2					18. Mother's Name	e (First, Middle,	, Maider	Surname)		
/lan	uld be Jenta rked tic ev	To B	Gaspard Chéné						Mary Jan	e Frase	r			
ar)	2 sho and I Is ma		19a. Informant's Name/Relationship (• •					and Number or Rur ${\sf FRd}$. Roc				Zip Code)	
ره ح	1 and Health sm 27 ther tr		Linda Ulrich / Ni 20a. Method of Disposition	ece	20h Pla					Date		ocation - City or	Town, State	
Baltimore,	ages nt of h t: If ite		1 ☐ Burial 2 🖾 Cremation 3 ☐		1	nce of Dispo metery, crei			1			ls Churc		
Ē	nit. Partme ortani injun		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Linear Legislation 1.1)		Nat:	ional	Crem 2. Name a	nd Addre	y = 02/12 ss of Facility J_{OS}					-
ñ	permi Depar Impor any ir		1. W. C.H.	Muy					nsin Ave.		_	gton, DC	20016	10
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused to one cause on each line	he death.	Do not ent	er the mo	de of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw Onset and De	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	Stroke -									Onset and Di	5411
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								
0	ped sit	niner	Sequentially list conditions, if any, leading to immediate cause Ener Una nying Cause (Disease or injury	b Due to (or as a	conseque	ence of):						- 1		
ر 0	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	CDue to (or as a	conseque	ence of):								
68760,	ate be hysicia he bu	ical		d										
3 ~		/Mec	IF FEMALE:	23c. If yes, outcome p	f progpan	107				1115		004 B-414-	th	-
1145 a	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	1 Ulive birth 2 4 Pregnant at t	⊇ ☐ Fetal o	death 3[⊒Ectopic p ⊒ Other <i>(</i> s		y 			23d. Date of de Month	•	ear
2/iu/08 ecords, P.	N requires that the deben signed by the should be detached	ed by Pl	Part II. Other significant conditions of Carotid Artery D	-	t not resul	ting in the u	nderlying	cause giv	en in Part I.				o the cause of de robably 4 □Ui	
~		omplet								24a. Was auto perfo 1□ Yes		death?	utopsy findings a completion of ca s 2 \(\textsquare\) No	vailable use of
/ita	siclan; Th certificate rector, pag	Be (25. Was case referred to medical examiner?	11				0,4	26. Place of Dear	th (Check only	one)			
CLAIRE on or Vital I	ys dir	ို	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1X Inpatien 28a. Date of Injury		R/Outpatier 28b. Time o			4 LI Nursing H	ome 5 Res		6 ☐Other (Spe	ecify)	
0,00	ig Te	tion:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м	28c. Inju Woi 1 □	k? Yes 2∐No	zod. Describe	now my	ary occurred		
JNF	il or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of injur	ry - At hon . <i>(Specify)</i>	ne, farm, st	reet, facto	ry, office		28f. Location (City or To			ural Route Numb	per,
HENNE DIVIS	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical C	29a. Certifier (Check only one) 1 ☑ Certifying Pl	nysician: To the best of miner: On the basis of and manner stat	examinati	rledge, deat on and/or ir	th occurrent envestigation	d at the ti	me, date and place opinion, death occu	, and due to the rred at the time	e cause(, date ar	s) and manner a	s stated. e to the cause(s)	
)	To th within To th сощр	Me	29b. Signature and title of certifier						se number			ate signed (Mon		
	0)			7 5	wil	ks	I	00063	3195		02/	10/2008		
	10		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,				0011				
	70 <u>- a.</u>		Steve Wilks MD 8	600 Old Geo	rget r's Signati	own R	d. Be	ethes	sda, MD 2	0814				
	Sta Regist	ate rar	FEB 1 2 20	08 France	, K	do	ants)							

			For State Registrar	State of Ma	aryland /		artment of H				iene eg. No.	2008	059	916
H	Physici	an	Decedent's Name (First, Middle, Last ALLEN CHRIST	•	CUMMIN	CS			2	2. Date of Dea Month 02			3. Time of D	Death
	/Medic	al	4a. Facility Name (If not institution, give		COLLIIN		4b. City, Town, o	or Location o	of Death			County of Death	1321	
_	The second		WMHS - BRADDOCK					RLAND		. D / D'. #1	_	LLEGANY		
ì	Funeral Director		5. Social Security Number 6. Security Number 212–56–3164 Usual Residence of Decedent	3 M OF 1	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours	Min.	B. Date of Birth (Month, Day 12/22/	, Year)	9. Birthp Coun Maryl		Foreign
	inyland ihow	_	10a. State 10b. County		10c. City, Tov							1	0d. Inside City	
	he Ma 28a-f s otified	Director	MD Carol:	Lne		E	Bethlehem			T	Ina Citiz	en of What Coun	1 Yes	2 NO
	3a or		4928 Bethlehem	Road				609			-	USA	.,,	
336	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give X Year or Dates:			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No			ify Yes or No- ican, etc.)		4. Race - Americ Black, White, Specify:		
215-0036	72 hou 'nature dical E	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16	a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during mos	st of working	9 1	16b. Kin	nd of Business/Ind		
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		<i>DO NOT use retire</i> ad Worker				Sta	te of Ma	rvland	
Baltimore, Maryland 21	e filed al Hygi other vent, ti	Be C	17. Father's Name (First, Middle, Last)			_1.00	id worker	$\overline{}$	er's Name ((First, Middle,			, , , ,	
<u>yla</u>	should be filed ind Mental Hyg s marked other umatic event, t	일		Lehman		mmir			vetta.		Α.		laway	
Za	2 8 8 5		19a. Informant's Name/Relationship (T) Charles L. Cumming				ng Address <i>(Street</i> 1928 Beth				-			
Jre,	es 1 and 2 of Health fitem 27 i	1	20a. Method of Disposition	-	20b. Place	of Dispo	osition (Name of matory or other pla		Da	·		cation - City or To		
Ē	Pages ment of I tant: If its jury or o		1 ☐ Burial 2 反 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	1	erla	and Crema	tory						
Bail	permit. Pag Department important: I any Injury o once.		21. Signature of Funeral Service Ligens	dam	•	2:	2. Name and Addre 404 Deca					Funeral	Home, 2 1 502	P.A.
	Physician	60 V	23a. Pan1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each line	ne.			ing, such as	cardiac or			iid, iib	Approximate Interval Betw Onset and D	eath
	/Medicai		disease or condition resulting in death)	Due to (or as	a consequence	e of):							5 minus	. 11
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98/90	icate b physic s the b	dical		d										
C. Box (eath cert attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		⊒Ectopic pregnanc ⊒ Other (specify) _	Ç y			2	3d. Date of delive Month		ear
٦.	w requires that the d teen signed by the should be detached	by Ph	Part II. Other significant conditions co	ontributing to death b	ut not resulting	in the u	nderlying cause gi	ven in Part I	l.	23e. Did to	bacco us	se contribute to the	ne cause of de	eath?
Records,	equire en sig ould be	ted b								1 🗆 Y	es 2	No 3□ Prot	ably 4 □U	nknown
ě	e law r has te	Completed								24a. Was a autop perfor	sy	24b. Were auto prior to co death?	psy findings a mpletion of ca	vailable use of
Vital	40		25. Was case referred to medical					26 Place	e of Death		2 V No	1 ☐ Yes	2□ No	
	Physician: The lave this certificate has all director, page 2.9	To Be	evaminer?	Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatie	nt 3 DOA Ot	hor:				S ∏Other (Specia	 jy)	
o n	ding Ph h. After th funeral	on: 1	27. Magner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time o	Wo			8d. Describe h	ow injury	y occurred		
DIVISION OF	or Atten ter deat iirector: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj building, et	ury - At home, c. (Specify)	farm, st	reet, factory, office]Yes 2□		8f. Location (S City or Tow	street and n, State)	d Number or Rura)	al Route Numi	ber,
	To the Hospital of within 24 hours all To the Funeral Completely filled in	Medical Co	29a. Certifier 1	ysician: To the best liner: On the basis o and manner st	f examination a	ge, dea and/or in	th occurred at the to exestigation, in my	time, date a opinion, de	ind place, a eath occurre	and due to the o	cause(s) date and	and manner as s I place, and due t	tated. o the cause(s))
	To the within To the complex	Me	29b. Signature and title of certifier				29c. Licen			1	29d. Date	e signed (Month,	Day, Year)	
	1		Panas tim	anle-			00)		7	. 10	08	-000
	ntos	8 9	30. Name and address of person who o	completed Ause of d	leath (Item 23a		Print) ed for a	2000	N.	E CL	unb (etlana M	0,219	502
	Sta	te	31. Date filed (Month, Day, Year)	32. P gistr	ar's Signature	- 1/								

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Charles Year Leroy Cross /Medical February 12, 2008 1:55 PM 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Locetion of Death 4c. County of Death Devlin Manor Health Care Center Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 1፟፟፟∭ M 2□ F Months Days Hours Min 219-03-9295 86 07/23/1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director MD Allegany Cumberland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Brentwood Street 21502 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married MYes 2□No 1939-1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Pipefitter Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Bessie Marion Free 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Cross / Wife 910 Brentwood Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 02/15/2008 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 art. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Eltypeine 'n Dementin Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐-No 3 ☐ Probably 4 ☐ Unknown à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ₩o 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) ٩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 11) Certifying Physician: To the best of my knowledge, death continued at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

death certificate be executed ed by the attending physician end detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, cate hes been signed by I page 2 should be detact this certificate hes To the Hospital or Attanding Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; t

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23a or 28a-1 shot any injury or other traumatic event, the Medical Examinar must be notified at

Physician

/Medical

Examiner

4+

Medicai

.. Anthony J. Bollino, Jr, M.D., nds 31. Date filed State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

Clin ho

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

922 National Highway, LaVale, MD DRAGE

29c. License number

D17565

29d. Date signed (Month, Day, Year)

February 13, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Barr Colwell 2008 11:45 Feb. /Medical а 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7209 Cedar Avenue Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 505-52-1920 98 26, 1909 Nebraska Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or them." 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ▼ Yes 2 No Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7209 Cedar Avenue 20912 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1927 If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White <u>ک</u> 3 TyWidowed 4 ☐ Divorced Year or Dates: 1969 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Colwell ၉ Mary_Potts Bergen 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Colwell-Son 7209 Cedar Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2-13-2008 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licenses 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Presbyesophagus 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes No. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page performed? this certificate 2√ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SAResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death To the Funeral Director: Hospitai

Registrar

State

29a. Certifier

29b. Signature and title of certifier

FEB 11

Medical

8901 Wisconsin Avenue, Bethesda, MD 20889 Susan Brunsell, M.D. 31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0053943

29d. Date signed (Month. Dav. Year)

February 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dorothy Fay Cochran 11:20A Feb. 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Kensington Kensington Assisted Living If Under 1 Year | If Under 24 Hrs. Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 94 567 20 6298 12, 1913 CA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d, Inside City Limits 10c. City, Town or Location show ms 23a or 28a-f shov must be notified at 1 XYes 2 No Funeral Director MD Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 3618 Little Dale Road <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Stone John Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4519 Roxbury Drive Bethesda, MD Dennis Cochran/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 02/08/2008 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Joseph Gawler's Sons, Inc. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 20016 Washington, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Physician /Medical Due to (or as a consequence of): **Examiner** Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ner requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical the as 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 Other (specify) P.0. ed by the a 9☐Unknown 23e. Did tobacco use contribute to the cause of death? sign**e**d t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Mild cognitive deficit, hearing deficit, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No urinary tract infection, hypertension 24a. Was an autopsy performed? res 2 No certificate has 25. Was case referred to medical examiner? 26. Place of Death Check onl one Assisted Living Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 Tes 2**X**] No P After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02/08/2008 D34472 30. Name and a sees of person who completed cause of death (It a 23 10400 Connecticut Ave., #206 Kensington, MD 20895 Lynne Diggs MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 11

2008

Physician /Medical Examiner that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natuury or other traumatic event, the Medical.

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and -tran attending physician a for use as the burialbeen si has page certificate After this

Records, P.O. Box 68760,

Division or Vital

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within 24 hours after death To the Funeral Director: completely filled in by the f

Physician/Medical þ Completed Be 2 Certification:

IF FEMALE: 23b. Was decedent pregnant

	25.	Was case re examiner? 1 ☐ Yes	,	to	medical
١	27.	Manner of E	Death		10

5 ☐ Pending investigation 6 Could not be determined

2008 Deserve

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

FEB27

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620 32. Registrar s Signature 31. Date filed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Debra May DuVall February 1:47 P. M 18, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11 W. Baltimore St. Apt. Hagerstown Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 219-66-0517 52 4, Aug. 1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√2 Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore St. Apt.#101 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Wright, Sr. Betty L. Smoot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 W. Baltimore St. Apt. #101 Hagerstown, MD 21740 James E. DuVall (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Smithsburg Crematory 20, 2008 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) almonary Disease Obstruc Chronic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 □Unknown 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

7 Is marked other than "natu traumatic event, the Medical

Department of Health and Mental I Important: If item 27 Is marked or any injury or other traumatic evenoce.

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans ding pl attending for use a ed by the a detached f page 2 should certificate has After this

Examiner Physician/Medical Be Completed by Certification: To

s after dec. ral Director: After filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours a

To the

completely

Medical

24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2□ No 1□ Yes 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

Dous 7 2 85

200 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kuilpillai GIJ.

MD

24 N. Walnu

#10Z, Hagerstown 31. Date filed (Month, Day, Year) 32. Registar's Signature FEB 2 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29 2008 2:45 p Louise Cecilia Davis 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Clinton Nursing, LLC Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 🖫 F 86 579-18-9288 03-09-1921 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1y Yes 2 No Prince George's Brentwood 10e. Street and Number 10g. Citizen of What Country? 3802 38th Ave 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify. White 3X Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) High School Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George McClosky Maud Louise Padgett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Davis / son 38 Feversham Ct. Travelers Rest SC 29690 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ft. Lincoln Crematory 2-9-2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd. Brentwood MD 20722 Immediate Cause (Final Candisvanular resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If Ite any Injury or ot

Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
Int. If Item 27 is marked other than "natural", or Items 23a or 28a-f shov ant: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with Hygiene.

Saltimore, Maryland 21215-0036

certificate be executed ed by the a detached f signed I has To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by

Division or Vital Records, P.O. Box 68760,

State

iicai Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dim to (or as a consequence of): c. Due to (or as a consequence of): d.											
ysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year									
neted by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available									
EoS			autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No									
מ	25. Was case referred to medical examiner?	26. Place of Death (C										
2	1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ♦ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)									
ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d Work? 1 Yes 2 No	Describe how injury occurred									
Serunc	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)									
lical		ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated										

29c. License number

DKS 365

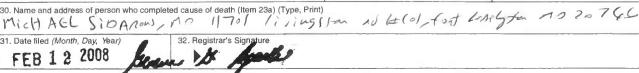
29d. Date signed (Month, Day, Year)

02-05-2008

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 1 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** PM NO 2008 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. dity, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) MARGIANO 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗹 F Director 229-26-1582 th Larol (Na Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 21 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes Specify þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACKSON 2 ober 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Important: If Item 27 is any injury or other trai 1.09 RESTUILLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) SUH LONG 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ewis FUNERAD Alexander KS 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on eact/line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner OROM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical been signed by the attending p should be detached for use as: IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Dinknown 1 ☐ Yes 2 □ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed 1∐ Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No ၀ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature d title of certif Đ cause of death (Item 23a) (Type, Print) 30. Name and address of

Registrar DHMH 17 Rev 1/2001

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2008

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Roland R. Davis + EBRUARY 2008 0045 4c. County of Death NIOSAICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1937 ΜĎ 10d. Inside City Limits TYTYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Construction 18. Mother's Name (First, Middle, Maiden Surname) Pauline Ethel Bostiek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10709 Griffin Rd., Berlin, MD 21811 20c. Location - City or Town, State Delmar, DE Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10006 2916 FEBRUARY 09, 2008 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

SVETLAND GUNCKLEZ 1415 SOUTH DIVISION SUITE B SALISBURY MO 21804 31. Date filed (Month, Day, Year) FEB 12 2008 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

Registrar

filled in by the funeral

after death

To the Hospital within 24 hours a

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Box 68760,
P.0.
Records,
r Vital
Division c

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:36 AM James Thomas Dove February 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 1 3 M 2 □ F Director Aug 07 1940 DC 215-36-5159 Usual Residence of Decedent 67 with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Westminster Director MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 2 iner must be no USA 21157 1725 Gablehammer Road "natural", or items 23a edical Examiner must l death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the joins. Owner J. Dove & Assoc LLC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary B. Herbert Harold I. Dove ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 21157 1725 Gablehammer Road Carole G. Dove/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/13/2008 1 ☐ Burial 2 ☐ Removal from State Hampstead, MD Carroll Cremation, Inc 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Printed Admeradiin Home and Chapel, P.A. - Convice 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw COMPLICATIONS OF PANCREATIC, CANCER 4nsMonths Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No To the Hospital or Auching within 24 hours after death.

To the Funeral Director; After this certificate has the Aumeletely filled in by the funeral director, page 2. autopsy performed? 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes - 2 THE 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 WIL February 6,2008 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave., BALTIMORE, MD 21215 10 Hospital of Balt, more Sinai NOM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Amended Items 23a Part I & 25 per Physician 02/14/2008 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					State of N	ıaryıar		rtment <i>tificate</i>			мептат ну	giene Reg. NO A I	00 (15026
			1. Decedent's Name (i	First, Middle, La	st)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-	2. Date of De		1 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3. Time of Death
	Physici		Helen	Evange	line Dav	/is					Month Febru	Day ary 3,20	Year	3:50 PM
	/Medic Examir		4a Facility Name (If no)			41	o. City, Town, o	r Location of Deat			3:50 PM
			9914 Chu	rchill I	Orive					Upper	Marlboro	Princ	e Geor	ap!c
	Funeral		5. Social Security Num	ber 6. S	Sex 7. A	ge (In yrs.	last birthday)	If Under 1		If Under 24 Hr				e (State or Foreign
	Director		241-54-014 Usuel Residence of De	42	I□M 24€F	74	Yrs.	rthday) Yrs. If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 9. Birthplace (State or F. Country) North Carol						Carolina
	within 72 hours aftar death with the Maryland ana. than "natural", or items 23a or 28a-f show ta Madical Examiner must be notified at	_		0b. County		10c. Cit	y, Town or Loc	ation		<u>_</u>			10d.	Inside City Limits
	ar death with the Marylar tterns 23a or 28a-f show her must be not the Jai	Funeral Director	MD]	Prince (George's	U	pper Ma	rlbor	0					1 Yes 2□ No
	1 P P P P P P P P P P P P P P P P P P P	Dire	10e. Street end Number	er				10f. Zip C	ode			10g. Citizen of V	What Country?	?
	ath w	ra E	9914 Chui	rchill I	Drive			207				US	Α	
	tar dea ttems	n n	11. Marital Status		12. Was Decedent Armed Forces	t Ever in U	,S. 13. W	as Deceder Yes, specify	nt of His	spanic Origin? (n, Mexican, Pue	Specify Yes or No orto Rican, etc.)	- 14. Rac	e - American I ck, White, etc.	
20	', or I	Ϋ́	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2√☐ If Yes, Give	No		□Yes 8		Specify:			· Black	
Maryland 21215-0020	in 72 hours afte "natural", or h edical Examin	8		5. Decedent's Ed	Year or Dates:		16a Decede	ent's Usual (Эссира	tion		16b. Kind of Bu	usiness/Indust	try
215	7 nin 7	3 Widowed 4 Divorced Year or Dates: 1 Yes, Give Year or Dates: 1 Yes, Give Year or Dates: 1 Specify: 1 Specify										l do. King of Di	10.1100041110001	~,
21	7 7 4 7	ĕ	Elementary/3econds	ary (0-12)	College (1-4or 4	J+)	E	ducat	or			Schoo1	Syste	m
2	be filad ttal Hygie d other event,	Be	17. Father's Name (Fir.	st, Middle, Last)						18. Mother's Na	ame (First, Middle	Maiden Suman	ie)	
yla	should be nd Mental marked o	2	Lindsey I	Bowser						Lois	Harrell			
Jar	2 sh and aum		19a. Informant's Name				19b. Mailing	Address (S	Street a	nd Number or F	Rural Route Numb	er, City or Town,	State, Zip Con	de)
e)	1 and Haaith em 27	-	Louis E.		- Spouse					L Dr., 1	Upper Ma			
Ö	it of F		20a. Method of Disposi		Removal from State	C	Place of Dispos semetery, crem	atory or othe	er place	•	Date	20c. Location -		100
Baltimore,	t. Pa rtmer rtant:		4 Donation 5			Ch					02/11/0	3 Chelte	nham,	MD
Ba	permit. Pages 1 and Department of Haalit important: If Item 27 any Injury or other to		21. Signature of Funer	al Service Licen	ISOO		/ 22.	Name and A	Address	s of Facility	Latney's	Funeral	Home	
	a	_	uf		MU) 2	178					.,NW, Wa		, DC 2	0011
No.	9,		23a. Part1. Enter the o shock, or heart fa	ailure. List only	one cause on each l	d the deati ine.	n. Do not ente	r the mode o	of dying	, such as cardia	ac or respiratory a	rrest,	Inte	pproximate erval Between aset and Death
y de	Physician /Medical		Immediate Cause (Fin	al	_								1	oct and boats
	Examiner		disease or condition resulting in death)		a. Liver								1	
	D 5	ne				0) 0) 804	r as a consequ	ierice oi).					1 .	
	tificate be executed g physician and as tha burial-transit	edical Examiner	Sequentially list condit	ions,	b	Due to (o	r as a consequ	ence of):						
60,	be ex	E E	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	ng Iry	C.								1	
68760,	phys phys s tha		that initiated events resulting in death) Last			Due to (or	r as e consequ	ence of):					-	
	= 0 0				d								!	
Вох	atter after	Clar	Death Other Levies	-A Alat							1		'	
P. O.	tha o	Physician/N	Part II. Other significar	nt conditions co	ontributing to death b	out not resu	ulting in the und	derlying caus	se give	n in Part I.		110		e cause of death?
S.	v requiras that the death cer been signed by the attendir should be detached for use	by P									. 10	Yes 20 No	3 Probabi	ly 4 □ Unknown
Ĕ	quira en sig	8										an autopsy	24b. Were a	autopsy findings ble prior to
Division of Vital Record	Tha law requiras that tha death cer ate has been signed by the attendir paga 2 should be detached for use	Completed									pend	med?	comple of deat	etion of cause
œ —	Tha I	ĕ									1 🗆	res 21X No	1 □ Y€	es 2□ No
Ħ	ian: ortifica ctor,	Be	25. Was case referred examiner?	to medical						26. Place of De	eath (Check only o	ne)		
<u>~</u>	hysic nis ce il dire	၉	1 ☐ Yes 🙀 ☐ No		Hospital: 1 ☐ Inpatio	ent 2 🗆	ER/Outpatient	3□ DOA	Other	4 Nursing	Home 5⊠ Resi	dence 6 Oth	er (Specify)	
Ĕ	ing P	Ö	27. Menner of Death 1 20Natural 5	i ☐ Pending	28a. Date of Inju	y Year)	28b. Time of Injury	28c.	Injury Work	at ?	28d. Describe	now injury occur	ed	
<u>s</u>	Attending Physician: or death. sector: After this certific. by the funeral director.	cat	2 Accident 3 Suicide 6	investigation Could not be		1		М		es 2 □ No				
N	or Al after Direct In by	Certification:	4 Homicide	determined	28e. Place of Inj building, et	c. (Specify	me, farm, stree	et, factory, o	ffice		28f. Location (Street and Numb vn, State)	er or Hural Ho	oute Number,
_	To the Hospital or Attending Physician: Tha lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, paga 2	aic	29a. Certifier 1X	Certifying Phy	sician: To the best	of my know	wledge, death	occurred at t	he time	, date and place	e, and due to the	cause(s) and ma	inner as state	d.
	ne Ho n 24 h	Medical	(Check only 2 one)	Medical Exam	iner: On the basis o and manner st	f examinat	ion and/or inve	stigation, in	my opi	nion, death occ	urred at the time,	date and place,	and due to the	cause(s)
	To the To the comp	Z	29b. Signature and title	of certifier						number		29d. Date signe		
	1-		DIn	tuse Do	0			4) () (0005		Telo.	7.2	008
	G		30. Name and hess	of person who c	completed cause of d	leath (Item	23a) (Type, P	rint)				, - 51		
	252-1		Da. Do	na Les	Kyski.	- 92	00 Ba	Sil (غان	rt - U	ipper 1	Varlbor	apl is	20174
	Stat Registra		31. Date filed (Month, D	1 3 2008	2. Registr	ar's Signal	ture	2			* *			

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma		epartmei Certifica			nd Me		giene	8	05927
će.	Physic		1. Decedent's Name (First, Middle, Last,	Dor	rey) 2 	2. Date of De	FDay 20	NO P	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Lorien Nur	street and number)	House	4b. City	Jown, or	Location of	Death S	3	4c. Coupty	of Death	
1	Funeral Director		5. Social Security Number 6. Se	x]M 2 ∑ F	(In yrs. last birtho	Months	Days	If Under 2 Hours	4 Hrs. 8 Min. A	Date of Bir (Month, Da .ug . 3	1917	9. Birth Cou Ma	place (State or Foreign intry) ryland
	Maryland I-f show fied at	tor	10a. State 10b. County MD Howard		10c. City, Town o	r Location SSUP							10d. Inside City Limits 1 ☑ Yes 2 □ No
	3a or 28s	i Director	10e. Street and Number 10025 Guilford	l Road		10f. Zi	p Code	794			10g. Citizen of	What Cou	•
920	iges 1 and 2 should be filled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic avant, the Mudisal Evanfrat must be nuitfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Worldowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.	13. Was Dece If Yes, spe		spanic Origin, Mexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.)		ce · Amer ck, White	ican Indian,
21215-0036	d within 72 h giene. er then "netu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th) (G	ecedent's Usualive kind of wife. DO NOT L	ork done d use retired,	ition luring most	of working		16b. Kind of B		ndustry f Aging
Maryland	should be filed nd Mental Hygir markad other imatic avant, II	To Be C	17. Father's Name (First, Middle, Last) Henry Moore							First, Middle, n Car	Maiden Sumar roll	ne)	
	and 2 sho		19a. Informant's Name/Relationship (Ty Charles E. Dor		213	lo ord	char		Lai	ndove	er, City or Town, r . MD		
Baltimore,	2 2 2 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Ω	cemetery,	prd Me	other place	k 2	Dat 2/16,	/08	20c. Location	bia	, MD
Balt	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Lio	Luga	ed)								ome, PA , MD20850
	Physician /Medical		23a Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	cardi	enter the mod		f, such as co	_		rrest,		Approximate Int - al Between On et and Death
8760,	cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a	consequence of):	rte	5	di	reg	556			loger
O. Box 6	The law requires that the death certificate te has been signed by the attending phy; bage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 10 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								ite of deliventh	rery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but	not resulting in th	e underlying o	cause give	n in Part I.			obacco use cont		the cause of death?
al Record	:: The law requicate has been ; page 2 should	Completed							_		rmed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: Atten this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time		28c. Injury Work	r: 4 Nurs	sing Home		ne lence 6 □Oth now infury occur		fy)
Divis	ial or Attandin s after death. al Diractor: Af ed in by the fur	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factor			28f	Location (S City or Tox		oer or Run	al Route Number,
	To the Hospital or within 24 hours afte to the Funaral Dir. completely filled in It.	edical (29a. Certifier (Check only one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin Physical Examination (Check one) 1 Certifyin sician: To the best of ner: On the basis of e and manner state	xamination and/o	eath occurred r investigation	at the time i, in my op	a dale an.! inion, death	clana and occurred	due to the at the time,	date and place,	anner at t	taled to the cause(s)	
)	To the To the complet	W	29b. Signature and title of certifier	6	ith (Item 23a) (Ty)	29	c. License	number	ζ		29d. Date signe	d (Month,	Day, Year)
ng:	Sta	te	30. Name and address of person who co Cary Kg Zlow Mi 31. Date filed (Month, Day, Year)	mpleted cause of dea / 08051 32 Registrar'	s Signature	pe, Print)	gre.	RdC	sh	451	Mel	2/0	345
	Registr		FEB 1 3 200		, K. 1	parte							

	01408 nes Patrick D	S elar		r Print in Black Ind				gible.	
Jaiii	ies rather L		I- For State	of Maryland / Depar <i>Cert</i> i	ificate of De			eg. No. 20	08 0592
	Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last				2. Date of Dea	h	3. Time of Death
Me	dical Exam	iner	James Patrick Del		1.00	-	Month February		1146 hrs
*			 Facility Name (if not institution, give 10716 Bishops Street 	e street and number)		y, Town, or Location of I hopville	Death	4c. County of De Worcester	eath
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. las		nder 1 Year If Under 2		th (MM/DD/YYYY) 9.	Birthplace (State or Foreign
	Director	1	218-72-2297 12	M 2 F 49	Yrs. Mo	nths Days Hours	Min. 4/6/1	958	Country) MD
	ě.		Usual Residence of Decedent 10a. State 10b. County	100 City T	own or Location				10d. Inside City Limits
	f Iow an		MD Worces		hopville				1 Yes 2 No
	aryland 8a-f sh at onc	Director	10e. Street and Number	scel DIS		Zip Code	1	0g. Citizen of What C	
1004	ith the Maryland 23a or 28a-f show notified at once,		10716 Bishop St.			21813		USA	
_	n with	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		edent of Hispanic Origin ecify Cuban, Mexican, F			nerican Indian, Black,
	r death wi , or items	F	1 Never Married 2 Married	1 Yes 2 X No			dono racan, etc.)		White
	hours after 'natural'', Examiner	by	Widowed 4 Divorced Divorced Specify or	If Yes, Give Year or Dates: Ity highest grade completed)		2 X No specify:	nd of work done	Specify: 16b. Kind of Busine	
	72 hou n "nai	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		working life. DO NOT us	se retired)		
	5-0036 lled within 72 Hygiene. I other than "	duc	12		Builder			Constru	ction
	filed of Hyging ed oth	Be Co	17. Father's Name (First, Middle, Last) James P. Delapp				Name (First, Middle, Agnes McKi	•	
	21218 ould be fill Mental H marked ic event, I	To B	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Addr	ess (Street and Numb			tate, Zip Code)
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		Rebecca D. Delapp	/ wife		ishop St			
	Pages I an nent of Hea ant: If iten		20a. Method of Disposition 1 Burial 2 X Cremation 3		ace of Disposition (I ematory or other pla		Date	20c. Location - City	y or Town, State
	Limon Page tment tant:		4 Donation 5 Other Specify:	Cap	e Henlope			Frankfor	
	Baltin permit. Departm Importa injury o		21. io ature of Funeral Service Lice	101		and Address of Facility William St.			l Home
	Physician		23 Part I. Enter the disease, or comp						Approximate Interval
ساور الم	/Medical		f filure. List only one cause on ea Immediate Cause (Final disease a.	Oxycodone intoxica	ation				Between Onset and Death
4	Adminion		or condition resulting in death)	Due to (or as a consequence of):					
		Jer		Due to (or as a consequence of):					
		zaminer	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):					
	outed nd transit		events resulting in death) Last d.						
	Box 68760, redeath certificate be execut the attending physician and red for use as the burial - trai	cian/Medical	X UNPENDED	AMENDED #23a,27,28a-f, pe	erME.g877 3.	/11/08 TT			
	Box 68760 e death certificate b the attending physied for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy		pregnancy	23d. Date of del	ivery Day Year
	x 68 th certi ttendin r use a	sicia	past 12 months?	4 Pregnant at time of dear	_		or egricancy	Morar	Day
	Bo he dea y the a thed fo	Phys	1 Yes 2 No 9 Unknown	9 DIKHOWH	u dina in the condent	ing squag given in Bert	1 230 Did t	ohacco use contribut	e to the cause of death?
	ords, P.O. w requires that the speed speed by should be detach	ठ	Part II. Other significant conditions	contributing to death but not res	sulang in the underly	ying cause given in Part			Probably 4 Unknown
	'ds, equire een sig ould b	Completed		·			24a. Was		e autopsy findings available
	Recor The law icate has by	ğ						rmed? deat	to completion of cause of h? Yes 2 No
	un: The	ادہ ا	25. Was case referred to medical			26.Place of Death (C	Lateral Lateral	2 10 1	165 2 110
	n of Vital Rec ing Physician: The After this certificate funeral director, page	To B	1 ✓ Yes 2 No		R/Outpatient 3		Nursing Home 5	Residence 6	Other: Scene
		ë.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	1 1 2	now injury occurred ngested oxyc	codone
	Division Bopital or Attend 24 hours after death. Funeral Director:	Certification:	2 Accident Investigati	28e Place of Injury - At hor	Fnd 11:35 a	EMT 22			r Rural Route Number, City
	Div ital or ars after ral Dir	ertif	3 X Suicide 6 Could not determined	be		,			ishopsville, MD
	Div Hospital o 24 hours af Funeral D	alC	29a. Certifier Certifying Physici	an: To the best of my knowledge	e, death occurred at	the time, date and plac	e, and due to the cau	se(s) and manner as	stated.
	To the How within 24 h To the Fur completely	Medical		On the basis of examination and and manner stated.	d/or investigation, ir		urred at the time, date		
		Σ	29b. Signature and title of certifier	1		29c. License number O.C.M.E.		29d. Date signed February 19,	
1			30. Name and address of person who	COMPleted cause or death (from		O.O.IVI.E.		, oblidary 10,	
				stant Medical Examiner		reet, Baltimore, M	D 21201		
			31. Date filed (Month, Day, Year) FEB 2 0 21	32. Régistrar's Signatur	y Spark		OCME		
	Regis	uar	FEDAVE	AND THE PROPERTY OF					

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		State of Maryland / Department of 29d per dr., g876, 02:126.08	r be am	2. Date of Death	3. No.∠ U U O	3. Time of Death
hysici		Kathleen Ann Donoghue		Month February	Day Year y 11, 2008	0050
/Medio Examir			n, or Location of Death	I COLUCIE	4c. County of Deat	
		Harford Memorial Hospital Havre	de Grace		Harford	
ıneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day		8. Date of Birth (Month, Pay,) 2/15/195	(ear) 9. Birtl	nplace (State or Fore
rector		Usual Residence of Decedent		2/15/195	9 Mar	yland
Mo #		10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Lim
	to	MD Harford Aberdeen				1 ∏X Yes 2 □
or 28a-f ehow a cotified at	Director	10e. Street and Number 10f. Zip Code	9	100	g. Citizen of What Co	untry?
23a C		601 Cornell St. 21	001	τ	J.S.A.	
l, or items 23s or 28s-f shov samber must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
0	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No If Y	lo Specify:		Specify: Wh	ite
"natural", adical Exe		15. Decedent's Education 16a. Decedent's Usual Occ	cupation	16	Sb. Kind of Business/	
Med.	Completed	(Specify only highest grade completed) (Give kind of work don life. DO NOT use reti	ne during most of work ired)	ing		,
<u> </u>	mo:	12 Homemaker			In home	
oth vent	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
arke atlc	၉	John Albert Donoghue		a Clancy		
Important: If item 27 ie marked other then " eny injury or other traumatic event, <u>the Ma</u> <u>once</u> .		19a. Informant's Name/Relationship (Type, Print) Leigh Wall (Sister) 19b. Mailing Address (Stre				(ip Code)
em 27		Leign Wall (Sister) 1915 Bennet 20a. Method of Disposition 20b. Place of Disposition (Name of		berdeen,	MD 21001 Oc. Location - City or	Town State
# 15 / Or O		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other p	olace)			
ntan Line		4 Donation 5 Other (Specify) R. A. Ferris & C	1		est Cheste	I, PA
eny i		Tarring-	Cargo Fune			
		Aperdeen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of displace, or heart failure. List only one cause on each line.	, Maryland tying, such as cardiac	or respiratory arres	3399	Approximate Interval Between
sician and sicien and sicient and si	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	TENTAL ,	+ 1715	C	
by the attending phy: ached for use as the	Physician/Medical	d	23d. Date of deli Month	23d. Date of delivery Month Day Year		
gned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.		cco use contribute to	the cause of death
cete has been s , pege 2 should	Completed			24a. Was an autopsy performe	prior to death?	topsy findings avail- completion of cause 2 No
director, peç	Be	25. Was case referred to medical examiner? Hospital:	Other	h (Check only one)		
<u>=</u> _ a	ر ت ت	1 All patient 2 EH/Outpatient 3 DOA	4 Indising no	me 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)
: Atter	ation	Natural 5 Pending (Month, Day Year) Injury W	vork? □Yes 2□No		1-7	
To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Se .	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Funerel (dicai C	29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place, y opinion, death occurr	and due to the cau red at the time, date	ee(s) and Tanner as e and place, and due	etated. to the cause(s)
• •	Me		ense number	290	d. Date signed (Month	n, Day, Year)
To the Fur completely		Anda Novalions MD Do	2809 E		February	12, 2008
To the comple			, , ,			
To the comple		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW NOWAKOWSE MO	35 FOLA	TORD /	NE BE	ZAIR, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $10, \ 2008$ **Physician** Joan Amelia Ecker February 11:58 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 26, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Maryland 77 Director 214-28-0807 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2XNo Taneytown Carroll Directo Maryland Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 USA 3931 Walnut Grove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Store Telephone Operator 12 18. Mother's Name (First, Middle, Maiden Surname) To Be 17. Father's Name (First, Middle, Last) Mental Grace Copenhaver n and Menta Edgar E. Fair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3931 Walnut Grove Road, Taneytown, MD 21787 19a. Informant's Name/Relationship (Type. Print) Kenneth Ecker, Jr., son item 27 i Department of Health important: if Item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Lutheran Cem 2/15/2008 Taneytown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses 136 E. Baltimore St, Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESOPHAGEAL CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate touch. Enter Uncerbing Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MELLITUS DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Ampatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

4 hours a er deah. Funeral Director Al ely filled n by the fu within 24 hours a
To the Funeral C
completely filled To the

State Registrar

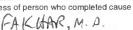
Medical

29a. Certifier

(Check only

WASIM 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



M.D 417

BALTIMORE E

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ST

D. TANEYTOWN MD 21747

1 🚅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CARLORS FEB 1 1 2008

and manner stated.

			For State Registrar	State c	of Maryland		artmer rtificat				ental			0 /	700
			Decedent's Name (First, Middle	e, Last)							2. Date		- 4 U U	3. 1	fine of Death
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13	Examir		4- 5-10 11: 24 11: 24 11: 21: 21: 21: 21: 21: 21: 21: 21: 21:					Town, or	Location	of Death		40	c. County of De	eath	-
			Shady Grove	Adventist	Hospita	1		ockv:					Montgo	mery	
	Funeral Director		5. Social Security Number 214-45-1330	6. Sex 1 ☐ M 2 🖾 F	7. Age (<i>In yr</i> s. <i>I</i>	as <i>t birthd</i> ay) Yrs.	If Unde Months	Days	If Under Hours	Min.		of Birth h, Day, Year 24, 1	7)	Birthplace (S Country) Peru	State or Foreign
	pu ,		Usual Residence of Decedent		140. 00	-									
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36	be filed within 72 hours after death with the Maryland stal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 🛣 Mar 3 □ Widowed 4 □ Divorced	If Yes. Gi	2X No ve		lf Yes, spe 1⊠Yes		an', Mexica Specify	rigin? (Sperin, Puerto F : : Peru		2.)	Black, W Specify:	hite, etc. hite	
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Ma	5 E N #		Benjamin Molin		3.0		-						own, MD		,
ē,	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	ia / bpous	20b. P	ace of Dispo	sition (Na	me of	;		ate		Location - City		
E O	Pages ent of nt: if i	,	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	emetery, crei Linco	-	,		2/13/	2008	Bre	entwood	. Mar	vland
Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 any injury or other once.		21. Signature of Funeral Service				2. Name a			ta.		e Tri		, mar	yrana
ä	Depar Impo any ir		MAG		ر	10	40 R	ockvi	ille		-		e, Mary	land	20852
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M	Physician		Immediate Couse (Final disease or condition		nary fi										et and Death
	/Medical Examiner		resulting in death)		(or as a consequ										
83	Lyammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	(or as a consequ	ionos of):								-	
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68	tificat ng phy as th	ledi													_
Вох	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2 □ Fetal		∃Ectopic p	regnancy					23d. Date of	-	.,
O. E.	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		nant at time of de		Other (s			-		- [Month	Day	Year
P.0	that the de led by the a detached t	Ph	Part II. Other significant conditi	ons contributing to d	eath but not resu	lting in the u	nderlyina c	eause aive	an in Part	I	23e	Did tobacco	use contribute	to the cau	se of death?
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Ö	w require been second	Completed									240	Was an			ndings available
Re	The lav	du										autopsy performed?	prior death	to completion?	on of cause of
Vital	ilcian: Th certificate ector, pag		25. Was case referred to medica	1					26 Plan	e of Death		es 2XN	io 1□Y	es 2□N	
>	Physician: this certificaral director, p	To Be	examiner? 1 ∐ Yes 2 X No	Hoepital:	Inpatient 2 □ I	ER/Outpatier	nt 3 □ D0	Othe	or.				6 ☐Other (S	necify)	
			27. Manner of Death	28a. Date	of Injury	28b. Time o Injury	f 2	28c. Injun Work					ury occurred	poony	
Siol	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pendir investi	gation	in, buy rour,	,	М		Yes 2□]No					
Division	i or Attend after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined Zoe. Place	e of injury - At ho ling, etc. (Specify		eet, factor	y, office		2	8f. Locat	ion (Street a	and Number or te)	Rural Rout	te Number,
	ospital o hours af uneral D ily filled ii														
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29a. Certifier 1 X Certifyii (Check only 2 ☐ Medical	ng Physician: To the Examiner: On the b and mar	e best of my know casis of examinat oner stated.	wiedge, deat ion and/or in	n occurred vestigation	at the tin	ne, date a pinion, de	nd place, a ath occurre	and due t ed at the	o the cause(time, date a	s) and manner nd place, and o	as stated. due to the o	cause(s)
	To the Ho within 24 I To the Fu Completel	Me	29b. Signature and title of certifie	or			29	c. License	e number			29d. D	ate signed (Mo	onth, Day,	Year)
	/		Brown	autu	W=	> 1		D64	502				Feb. 6	, 200	8
	>		30. Name and address of person	who completed cau	se of death (Item	23a) (Type,	Print)								
			Brian Carpente		9901 Med		Cente	er Dr	ive,	Rock	vill	e, MD	20850		
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signat	ture	ant I								

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		1- For State Registrar	Certific	cate of	Death			Reg	. No.		
	Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time										
"cal Exam	iner		sher					Month February 1	1, 2008	0353 hrs	
		4a. Facility Name (if not institution, give street ar		4	b. City, Town,		on of Death		4c. County of Death		
		Peninsula Regional Medical Cent	er		Salisbury				Wicomico		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1 \		nder 24Hrs urs Min.		(MM/DD/YYYY) 9.	reign	
Director		218-80-0323 1XM 2	F 46	Yrs.		ays Ho	urs Min.	09/28/	1961	CountryMaryland	
		Usual Residence of Decedent									
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/land -f shov		MD Somerset	Prin	cess .	Anne					1 Yes 2 No	
Maryland 28a-f show	Director	10e. Street and Number	_		10f. Zip Cod		_	100	g. Citizen of What C	ountry?	
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ms 2.	Funeral		Decedent Ever in U.S. ed Forces?		s Decedent of es, specify Cu			ecify Yes or No-	14. Race - An White, etc	nerican Indian, Black,	
deatl or ite	un_	1	res 2 X No					radan, etc.,			
after	by	3 Widowed 4 Divorced If Yes, Giver a part or Dates:			Yes 2 X				Specify: W		
hours natu	pa	15. Decedent's Education (Specify only highes	, ,		t's Usual Occu ost of working				16b. Kind of Busine	ss/Industry	
36 in 72 han "	ompleted	10	ege (1-4 or 5+) one	Di	sab1ed				None		
5-0036 led within 72 Hygiene. other than the Medical	E	17. Father's Name (First, Middle, Last)				18.Mot	her's Name	(First, Middle, M	aiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C										
212 uld buld bommark	To E	Robert Fisher, Sr. 19a. Informant's Name/Relationship (Type, Print	:) 1	9b. Mailing	Address (S	treet and I	Number or I	Vonne Sn Rural Route Numb	oer, City or Town, Si	tate, Zip Code)	
MD 2 d 2 shou lth and N n 27 is n	-	Robert Fisher, Sr.		3143	1 Peggs	v Nec	k Roa	d. Princ	ess Anne	MD 21853	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygers and mit. If item 23a or 28a-f 5th mit. If item 27 is marked other than "natural", or items 23a or 28a-f 5th more other trannatic event, the Medical Examiner must be notified at once		20a. Method of Disposition		e of Dispos	ition (Name of			Date	20c. Location - City	or Town, State	
nores la nu of H		1 X Burial 2 Cremation 3 Remo	vai iloiii otate	atory or oth			00/	15/0000	411	1 1	
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Balt permit Depart Impor	(Jimos L Nerma	M00295						1	MD 21853	
Physician		23 Part I. Enter the disease, or complications	that gused the death. Do	not enter th	he mode of dy	ing, such a	as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
'Medical		failure. List only one cause on each line. I-mediate Cause (Final disease a. Compli	cations of Pseuodm	yxoma	peritonei					Death	
xaminerئے	ı		r as a consequence of):								
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Box 68' e death certificate attending ed for use as	Physician/M	1 Vos 2 No 0 Heknows	Unknown	3 01	ner (opeany)						
O. Ent the cat		Part II. Other significant conditions contribu	ting to death but not result	ting in the u	underlying cau	se given i	n Part I.			e to the cause of death?	
, P.O ires that t signed by	d by							1 Yes	2 V No 3	Probably 4 Unknown	
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e law te has	Ĕ							perfor	med? deat		
tal Re		25. Was case referred to medical			26.P	lace of De	ath (Check			163 2 160	
/ita sicia is cer lirecto	o Be	examiner? Hospital:	Inpatient 2 ✔ ER	/Outpatient		Other			Residence 6 C	Other:	
of Vital ing Physician: After this certi uneral director	⊢	1 ✓ Yes 2 No 27. Manner of Death 28a.	Date of Injury 28	b. Time of I		Injury at V	Vork?	28d. Describe h	ow injury occurred		
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Division is or Attendii es after death.	lica	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injury - At home	, farm, stre	et, factory, offi	ce buildin	g, etc.			r Rural Route Number, City	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 44 hours after death. Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be deached for use as	Certification:		ecify)					or Town, Si	tate)		
Di Hospital 24 hours a Funeral E		29a. Certifier 1 Certifying Physician: To the	ne best of my knowledge, o	death occur	rred at the time	e, date an	d place, and	d due to the cause	e(s) and manner as	stated.	
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the b	pasis of examination and/onner stated.	or investiga	tion, in my opi	nion, deat	h occurred	at the time, date a	and place, and due	to the cause(s)	
FSFÖ	ž	29b. Signature and title of certifier				cense num	ber			(Month, Day, Year)	
		and			0	.C.M,E,			February 12,	2008	
		30. Name and address of person who complete									
		Ana Rubio MD. Assistant Med			Street, Balt	imore, l	иD 2120	1			
S Regis	tate	31. Date filed (Month, Day, Year) FEB 1 4 2008	32. Registrar's Signature	4 1	Could's						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Dawn Marie Field February 9, 2008 a™ /Medical 1:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9232 Bel Air Drive Mardela Springs Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 X F 39 214-82-9562 Director 10/17/1968 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9232 Bel Air Drive 21837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>accounts receivable</u> insurance permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, tit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Malcom Anstine Norma Dewey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Field/husband 9232 Bel Air Dr., Mardela Springs, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 2/11/08 Salisbury, MD JEHO TI Service Licensee Rolloway Funeral Home Professional Association 501 Snow Hill Ro., Salisbury, MD 21804 21. Ignatur 23a. Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause queen line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Overien Corcinoma 3 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical as the t attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the g 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Michknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼No funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending hours after death. 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State

PANPI 1 31. Date filed (Month, Day 13 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

Cours 11 2 trut, Solisbury, MD 32. gistrar's Signature

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DHMH 17 Rev 1/2001

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Februa

11. 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician FROEHlich 3,30 AM JEANNETTE STEHMAN 12,2008 FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9913 HOWARD EVERGIEEN AVENUE Olumbia 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 9, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 X F 1923 Virginia Director 722-05-0038 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21046 USA "natural", or Items 23a o 9913 Evergreen Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) realth and Mental Hygiene.
wr 27 is marked other ther "er traumatic ever Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked of any injury or other traumatic ew Elsie Schultz Jacob DeWitt Stehman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Froehlich/daughter South Street Williamsburg, MA 01096 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory | 02/13/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line.

Immediate Cause (Final disease or condition

a. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to wor as a consequence of): Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending physical for use as the 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s has autopsy performed? Yes 2X No certificate I 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

• Funeral Director: A letely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the l within 2

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Clement B. Knight, M.D. 11065 Little Patuxent Pkwy. Columbia, MD 21044

29c. License number

4113

29d. Date signed (Month, Day, Year)

bruary 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Gertrude Frankeberger 7:00 p M February 2008 11 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F March 01, 1918 053-05-0179 New York Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3451 Chiswick Lane, Apt. 75-1D 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Mamied 2 No 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Coordinator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) Schnapper Lena Rosenfeld 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Aaronson - Daughter 18629 Shady View Lane, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 02/13/2008 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or permission. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2X No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes

Department of Health an Important; If item 27 is many injury or other 27 is mony injury or other 2000. Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be ဥ

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed by the at d be detached for page 2 s spital or Attending Phy: hours after death. neral Director: After this y filled in by the funeral di

been

this

within 24 hours a To the Funeral Hospital

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1⊡Yes 2N🗸 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

determined

Hospital:

1 Inpatient 28a. Date of Injury (Month, Day

2 ER/Outpatient 3 DOA 28h Time of

28c. Injury at Work? 1 Tyes 2 🗆 Na Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

29a. Certifier

1 Natural 2 Accident

3 Suicide

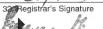
4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Other: 4 Hursing Home

State Registrar 31. Date filed (Month, Day, Year)



who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 9 3 6

			1 - State Registrar		C	ertificate of			eg. No.					
ı	Physici		1. Decedent's Name (First, Middle, La Margaret Mary Fir	*				2. Date of Deat Month Februa:	ry^{Day} , 2008	3. Time of Death 12:45 AM				
I	/Medic Examir		4a. Facility Name (If not institution, giv Shady Grove Adver	e street and number) ntist Nurs	ing Home	4b. City, Town, Rockvi	or Location of Dear	th	4c. County of De					
	Funeral Director		090-09-0196	ex 7. Ag □M 2ਊ F	e (In yrs. last birthda 88 Yrs.	y) If Under 1 Yea Months Day				irthplace (State or Foreign Country) W York				
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery	10c. City, Town or Germanton					10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?				
	s 23a	rai	35 Pickering Cour			208			Jnited Sta					
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-f show any injury or other treumatic event, I'm Medical Evar. Item is the rediffical at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ➡ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 4 If Yes, Give Year or Dates:		If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o <i>Specify:</i>	to Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Vhite				
9500-61212	ithin 72 ho le. len "netur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5	(Gi life		upation e during most of wo red)	rking	16b. Kind of Busines					
7	iled wi Hygien ther th		12 17. Father's Name (First, Middle, Last)			nerette	40 Matheda Al-	(E' Na'-1-4)	Theate	er				
<u>a</u>	id be fental h	To Be	Joseph Coffey	,				me (First, Middle, M t Hughes	Maiden Sumame)					
Maryland	2 shou and M is mar	-	19a. Informant's Name/Relationship (Турө, Print)	19b. Ma	iling Address (Stree	et and Number or R	ural Route Number,	, City or Town, State,	, Zip Code)				
გ დ	l and 2 fealth m 27 in		Theresa A. Finuca	ne (Daugh		Pickering	Court, G		n, MD 2087					
galtimore,	L. Pages ' tment of h tent: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other Specifi	y) //	Metro Cre	position (Name of rematory or other p opolitan natory	2	uary 11	20c. Location - City o	or Town, State				
a T	Departing Department Important In any in any		21. Signature of Funeral Service Lider	1500		22. Name and Add			neral Home					
n		23a. Part Envir the disease, or a mplications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest,												
	Physician		Imme at Cause (Fig.) Respiratory Failure Respiratory Failure											
	/Medical Examiner		Due to (or as a consequence of):											
l.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Pneumon:	La a consequence of):									
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to /or as a consequence of the consequence of											
Ω Ω	be exi		resulting in death) cast	Due to (or as	a consequence of):									
68/60 ,	ificate g phys as the	Medicai	•	d										
C. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	B⊟Ectopic pregnan B⊟ Other (specify)	су		23d. Date of d Month	lelivery Day Year				
<u>,</u>	n requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contribute	to the cause of death?				
cords	requires that een signed b hould be deta	ted k	Atrial Fibrilla	tion				1 🗆 Ye	s 2□No 3□F	Probably 4 Kunknown				
a)	62 C/	Completed	Stroke					24a. Was ar autops	24b. Were a	autopsy findings available completion of cause of				
VIIai H	ricien: The l certificate ha rector, page		Hypertension		·				No 1□Ye	? es 2□ No				
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA	-1	ath (Check only one	nce 6 □Other (Sp	nacihi)				
0		on: T	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injui (Month, Day		of 28c. Inj		28d. Describe ho		<i>весну</i>)				
DIVISION	ttending F death. tor: After the funera	catic	2 Accident investigation 3 Suicide 6 Could not be	1		M 1[☐Yes 2☐No							
2	oftel or At ars after d rel Direct fled in by	Certificati	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State)											
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ledical	one) Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occu	e, and due to the caurred at the time, da	use(s) and manner a ate and place, and du	as stated. ue to the cause(s)				
	To With	Σ	29b. Signature and title of certifier				nse number 8656		ebruary 7					
	4		30. Name and address of person who				D = -1 *	11. 100 0	0050					
	Sta	te	Ravi Passi, M.D., 31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	Ku., #200	o, KOCKVI	rre, MD Z	.0630					
	Danie A.	0.0	FFR 1 9 20	HX X	27 1	ARAEL II								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Louise Farr 12:48 February 12, 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months 1 3 M 2 □ F 88 June 19,1919North Director 579-88-8300 Carolin Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits 10a, State 10b. County Clinton Prince George 1 Yes 2 No Director Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20735 USA "natural", or items 23a 9106 Pineview Lane Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, o wn home Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the M Housewife 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pittman Florence McNair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie Alexander - Daughter 2104 Lakewood St. Suitland, Md.20746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Mem Cem Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/16/08 Suitland Maryland 4 Donation 5 Dother (Specify 21. Signatura of Funeral Serve Licens 20011 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part1. Effor the disease, or shock, or leart failure. List Immediate effuse (Final disease or condition resulting in death) o not enter the mode of dying, such as cardiac or respiratory arrest. **Physician** /Medical Due to (or as a consuluence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Ves 2 No has le 2 page certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA this 2 After thi funeral 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 / Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Sign ture and title of centifier

Registrar

State

axmi.

31. Date filed (Month, Day, Year)

FEB 15

Berwa

2008

7700 dd

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 12:42 AM Anna Goulden February 19 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 X F 12/21/1933 <u>Pennsylvania</u> 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Woodsboro

Race - American Indian, Black, White, etc.

Approximate Interval Between Onset and Death 2-2 M 0

Specify: white

<u>own home</u>

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

1 ☐ Yes 2 ♠ No

2020 No

28d. Describe how injury occurred

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Examiner Frederick Memorial Hospital 5. Social Security Number **Funeral** Director 177-26-6663 Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a, State ms 23a or 28a-f show must be notified at Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11434 Keymar Road United States 21798 of Health and Mental Hyglene. item 27 Is marked other than "natural", or Items other traumatic event, the Medic⊸l Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 2 Marcellus Charles Bolin <u>Marie Catherine Niederer</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norbert V. Goulden/ husband 11434 Keymar Road, Woodsboro, MD 21798 permit. Pages 1 ar Department of Heal Important: If item 2 any Injury or other? Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Resthaven Mem. Gardens 2/21/08 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford PA Funeral Home 2 Kri MO1222 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

Date of Injury (Month, Day Year)

the signed by t page 2 should certificate funeral director, After this

9 Unknown

4200 1C

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical

2 No

examiner?

1 ☐ Yes

27. Manner of Death

Natural 2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

Physician

/Medical

Physician: the

Completed by

Be

Certification: To

Division or Vital Records,

or Attending within 24 hours after death To the Funeral Director: filled in by Hospital completely

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 31. Date filed (Month, Day, Year) Registrar's Signature

Hospital:

State Registrar 2 R ER/Outpatient 3 □ DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

within 24 hours after death

To the Funeral Director:
completely filled in by the i

State

DHMH 17 Rev 1/2001

Medical

Juanita L. Smith, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

27. Manner of Death

1X Natural

2 Accident

3 Suicide

29a. Certifier

30. Name and a

4 Homicide

5 Pending investigation

6 Could not be determined

dress of person who co

32. Registrar's Signature

MD

mariner stated.

28a. Date of Injury (Month, Day Year)

2008 Registrar

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

em

pleted cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

9901- Medical Center Dr., Rockville, Md.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

Mary 08,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 1000

· ·				
State of Maryland	/ Department of	Health and M	ental Hygie	ne U

05940

			1 - State Registrar					Ce	rtificat	e of i	Death	ל		Reg. N	0.		
			1. Decedent's Name (First, Midd	fle, Last)		-							2. Date of De	ath			3. Time of Death
	Physici		Harold Elroy (Inegv									Februar		ay Q '	Year 2008	12:47 A.M
	/Medi		4a. Fecility Name (If not institution			ımher)			4h City	Town or	Location	of Death	rebruar			y of Death	12.4/ A.
	Examir	ıer					nd+n1			land		i oi bouiii			arre	10072	
			Garrett County 5. Social Security Number	6. Sex	OLIAL		In yrs. last b	inthoday)	If Under			er 24 Hrs.	8. Date of Bin		alle		olana /Chata as Fassion
	Funeral			1	M 2□F		myra. iaat o	Yrs.	Months		Hours		(Month, Da	y, Year)	Cou	
	Director		220-12-9753 Usuel Residence of Decedent			83_							April :	15 1	924	Mar	yland
and	*		10a, State 10b, Count	v		1	Oc. City, To	wn or Lo	ocation								10d. Inside City Limits
ary	8 8	2															1 □ Yes 2X No
Θ	-88 H	ctc		rett			0akla	and									
ith	2 2	Director	10e. Street and Number						10f. Zip	Code				10g. C	itizen of	What Cou	ntry?
Ę	23	62	16751 Garrett	Highw	ay				215	50				Un:	ited	Stat	es
. I Z I 3-UU30 within 72 hours efter deeth with the Maryland	# <u>5</u>	Funeral	11. Marital Status	12	2. Was Dec Armed F	edent Ev	er in U.S.	13.	Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	-		ce - Ameri	can Indian, etc
e e	유	F	1 ☐ Never Married 2 🛣 Ma	rried		2 _X No			1 ☐ Yes	74	Specify		, , , , , , , , , , , , , , , , , , , ,		Specif		
3 Sino	- 5	l by	3 ☐ Widowed 4 ☐ Divorce	d	Year or I	Dates:			103	2 (2)(10	Оресп				эрвсп	Wh	ite
2 P	net Real	Completed	15. Decede (Specify only high)	16	a. Dece	dent's Usu	al Occup	ation	set of work	ina	16b.	Kind of B	Business/In	dustry
F i	Man a	ple	Elementary/Secondary (0-12)	Jan Grade		1-4or 5+)		life.	DO NOT	se retired	1)	JSI OI WOIK	"ig				
, 3 D	ig E B	no:	12		1111			Sale	s Cle	rk				Lu	ımbeı	r Com	pany
filed A	oth of	Bec	17. Father's Name (First, Middle	, Last)							18. Moth	her's Nam	e (First, Middle.	Maide	n Sumar	me)	
д <u>Б</u>	Mental arked c	To B	Dewey Gnegy								Sad	ie Si	Laubaugh	า			
should	and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28a-f ehow aumstic event, the Mydical Examiner must be notified at	-	19a. Informant's Name/Relation	ship (Type	e, Print)		19	b. Maili	ng Address	(Street			al Route Numbe		or Town	. State. Ziu	Code)
72	カトコ		Mr. Robert Gne					512	Taene	r Di	1 037	Road	, Oaklaı	nd	MD '	21550	,
1 end	f Health and Meritam 27 is marke other traumatic		20a. Method of Disposition	-ву,	5011		20b. Place	of Disno	sition (Na	ne of	- 1		Date			- City or To	
<u> </u>	Pre Pre		1 Burial 2 □ Cremation	_	moval from	State	cemet	ery, crei	matory or o	ther plac							
mit. Pages 1 er	tant		4 □ Donation 5 □ Other (Garre		- 171		-	-	2/20/08	(akla)	and,	MD
	Department of Healt Important: If item 2 eny Injury or other once.		21. Signature of Funeral Service	Licensee				22	2. Name ar David	nd Addres	ss of Faci Burd	lock 1	Funeral	Hor	ne		
n 8	0 <u>-</u> • a		Katherine	Du	reite				21 N.	Sec	ond	St.,	Oakland	d, 1	1D 2	1550	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complica	ations that	caused the	e death. Do	not ent	ter the mod	le of dyin	g, such a	s cardiac	or respiratory a	rrest,			Approximate Interval Between
PH	ysician		Immediate Cause (Final disease or condition Acute M.I.												Onset and Death		
	Medical		resulting in death) a. Active II.1. Due to (or as a consequence of):												3 days		
E	kaminer		CAD										*******				
		Sequentially list conditions										-	years				
pe)sit	든	cause. Enter Underlying Cause (Disease or injury	≺	77												
хөсп	and II-tra	Examiner	that initiated events resulting in death) Last	C.			ipiden consequence									_	years
9 8	icien buria					(, , , , , , , , , , , , , , , , , , , ,	,-									
oo / ou,	physi the	dlo		d.													
X DO / DU,	ettending physicien and i for use as the burial-translt	Medical	IF FEMALE:	200	. 16											7-7	
~	ttenc or us		23b. Was decedent pregnant in the past 12 months?	230	1 Live	birth 2	pregnancy ☐ Fetal deat	th 3[⊒Ectopic p	regnancy				1		ate of delivionth	ery Day Year
Physicien: The law requires that the death	he ed	Physician	1 ☐ Yes 2 ☐ No , A \	A	4∏Preg 9∏Unkr		ne of death	5[Other (sp	pecify)						O THE T	02)
Tat the de	signed by the e	ج	9 ☐ Unknown	v 3													
s t	o de	b	Part II. Other significant condit	ions contr	ributing to d	ieath but	not resulting	in the u	nderlying o	ause give	en in Part	11.	23e. Did t	obacco	use con	tribute to t	he cause of death?
3 1	been si		DM Type 2										1 🗆 '	Yes 2	2 1No	3 Prol	pably 4 □Unknown
S §	s be	Completed	Chronic Renai	l Fai	lure								24a. Was	an	24b.	Were auto	ppsy findings available
E	e he	Ĕ					· · · · · · · · · · · · · · · · · · ·							rmed?		prior to co death?	mpletion of cause of
<u> </u>	ficet or, pa		or was selected between	1 3										2 N	o	1 🗌 Yes	2 No
	is certificete hes director, page 2	Be	25. Was case referred to medical examiner?	-	spital:					Oth	0.57		h (Check only o		-		
5 8	this aldi	2	1 Yes 2 No		100	Inpatient		_		JA I	4 L IN		me 5 Resid				(y)
e i	After	0	1 Natural 5 Pendi	ing	28a. Date (Mor	of injury oth, Day Y	(ear) 280.	. Time o Injury		8c. Injun Worl			28d. Describe I	now inj	ury occui	rrea	
VISION Attending	or: ,	cat	2 Accident invest 3 Suicide 6 Could	tigation					М	םי –	Yes 2]No					
DIVISION OF VICAL RECORDS, tor Attending Physicien: The law requires t	s after deeth. Il Director: After this id in by the funeral c	=		mined	28e. Plac build	e of Injury ling, etc. (r - At home, t (<i>Specify</i>)	farm, str	reet, factor	y, office			28f. Location (S City or Tox			ber or Run	al Route Number,
ב ב	rs al	Certification:															
Hospital	unel unel		29a. Certifier 1 Certifyi	ing Physic	cian: To th	e best of a	my knowledg	ge, deat	h occurred	at the tin	ne, date a	and place,	and due to the red at the time,	cause(s) and m	anner as s	stated.
H B	within 24 hours a To the Funerel C completely filled	Medical	one)	. CAGIIII16	and mar	ner state	d.	worin	resugation	, in my o	piriiOri, G6	zati i OCCUII	ed at the time,	uate af	iu piace,	and due t	o me cause(s)
Tot	To t com	Σ	29b. Signature and title of certifi	Pr \	0				290	. License	number			29d. D			Day, Year)
}			~	11/0	M	16					115	333			21	1/8/0	8
			30. Name and address of person	who com	pleted cau	se of dea	th (Item 23a) (Type	Print)							· ·	
		5	Dr. Thomas G.							eet	Oak	1and	MD 21	550			
	Sta	te	31. Date filed (Month, Day, Year			-	s Signature			,	Jak		, <u>61</u> .				

Registrar

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: if item 27 Is marked any Injury or other *** **Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show at

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should be filed within 72 hours after death v nd Mental Hygiene, marked other than "natural" -- n-

Baltimore, Maryland 21215-0036

notified

Examiner must be

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Director

Funeral

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Completed

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burial-tra physician the as nse ò the ed by been signe should be o page certificate

requires that the death certificate be executed

or Attending Physician:

this

After

death

within 24 hours after death To the Funeral Director:

funeral

the

filled in by

completely

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be Certification: To Medical

9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION

25. Was case referred to medical examiner? 26. Place of Death (Check only o Other: 4 Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending inve*s*tigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 28281

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WELSON BENJERS, 9131 PIS CATAVAY PD, CLINTON, MD 20735 31. Date filed (Month, Day, Year)

State Registrar

2008

			1- State of Maryland / Depa	rtment of Health and M		giene Reg. No.2008	05942
	8	g .	Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
	Physici /Medic		Harry Bradford Gamble, Sr.		Month Februa	Day Year 2008	02:15 AM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	
		¥	2 GAmble Lane	North East		Ceci1	
泰	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 705-09-9050 光弦M 2□F 93 Yrs.	Months Days Hours Min.	8. Date of Birl (Month, Da	y, Year) Co.	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		July 22	2, 1914 Mar	cyland
	yland now at		10a. State 10b. County 10c. City, Town or Loc	ation	-		10d. Inside City Limits
	a-f sh	ctor	Maryland Cecil North E	ast			1 ☐ Yes 2000 No
	ith the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
	ath w	<u>ra</u>	2 Gamble Lane	21901		United Sta	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Wyes 2 No If Yes, Give Year or Dates: 1943–46	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	ecify Yes or No Rican, etc.)		
ğ	2 hou	ted	15. Decedent's Education 16a. Decede	ent's Usual Occupation	10111	16b. Kind of Business/I	Industry
215	thin 7 e. an "r Med	Completed	Flementary/Secondary (0-32) College (1-4or 5+)	ind of work done during most of worki O NOT use retired)	ing	Veteran's	
7	ed wi ygien er th t, the	Con	12	ng Assistant		Administra	ition
Maryland 21215-0036	I be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Last)		,	Maiden Surname)	
Ë	should nd Me mark matic	으	John W. Gamble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Number or Rura	Willia		in Code)
<u>8</u>	nd 2 s ulth ar 27 is r trau			amble Lane, North			21901
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 20b. Place of Dispos	ition (Name of	Date	20c. Location - City or	
Ë	Pages nent of I ant: If ite ury or o		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bay View	TCDI	uary 008	North East,	Maruland
a	permit. Departm Importa any Inju once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Cr	ouch Fu	neral Home	naryranu
<u> </u>	99 = 50			7 South Main Stre			ry1and21901
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac of	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
9	Physician		Immediate Cause (Final disease or condition resulting in death)				UUKINI/
	/Medical Examiner		Due to (or as a consequence of):	100			
2.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a conse yience of):	een dise-			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Pulmas			
Ó	e exec an an rial-tr		resulting in death) Last Due to (or as a consequence of):	-			
8760	cate be executed physician and the burial-transit	dical	d coad MI.				
9	death certifica attending ph	Med	IF FEMALE:				
Box	attend for us	Physician/Me		Ectopic pregnancy		23d. Date of deli Month	very Day Year
Ö	at the de by the a	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			
J.	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Vital Hecords,	w requires that been signed to should be deta	d by			1 🗆 🗅	res 2 to 3 □ Pro	obably 4 Unknown
ပ္တ	s bee	Completed		1	24a. Was	an 24b. Were au	topsy findings available
Ĭ	The law icate has b	mo			autor perfo 1∐ Yes	psy prior to c rmed? death? 2☑No 1 ☐ Yes	completion of cause of
<u>ta</u>	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death		7	42,10
0	Physic this or al dire	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		me 5 DResid	dence 6 □Other (Spec	cify)
ב	ding PI J. After ti funeral	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Date of Injury 28b. Time of	Work?	28d. Describe h	now injury occurred	
DIVISION	or Attend after death. Director: / in by the f	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street	M 1 Yes 2 No	20f Location /6	Street and Number or Ru	mal Pauta Musebas
≧	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:	4 Homicide determined building, etc. (Specify)	st, taoloff, office	City or Tou		rai noute Number,
	ospita hours meral y filled	alc	29a. Certifier 1 ertifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the	cause(s) and manner as	stated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inversely and manner stated.	estigation, in my opinion, death occurr	red at the time,	date and place, and due	to the cause(s)
	Vith vith Com	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	n, Day, Year)
)			In coels NO	DO4823		0/8/08	
1	241VA		30. Name and address of person who completed cause of death (Item 23a) (Type, P	+ may st	FIICH	or Md:	21921
	Sta Registr		31. Date filed (Month, Day, Year) FEB 8 2008 Superior Signature	berli			

			For State	State of Marylar		artment of F		nd Me	, ,	0.0	08	05943					
	Ble .		Registrar 1. Decedent's Name (First, Middle, Las	t)	Cei	tillcate of	Deatii	2.	Date of Deat	eg. No./	00	3. Time of Death					
н	Physic		Barbara Ann Gru						Month Februa:	Day	Year						
	/Medi		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of		ebruai	4c. County		5:30a M					
	Examii	iei	Holy Cross Hospit			Silver						omery					
100	Funeral	X.	5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24	1 Hrs. 8.	Date of Birth		9. Birth	place (State or Foreign					
6	Director		577-36-2058	□M 2 🕽 🗱 78	8 Yrs.	Months Days	Hours	Min.	(Month, Day,	, 1929	Wash	ington, DC					
	P .		Usual Residence of Decedent														
	arylaı show dat	_	10a. State 10b. County	10c. Cr	ty, Town or Lo	cation					,	10d. Inside City Limits					
	Ba-f	Director		Montgomery		Silver S	pring					1 ☐ Yes 2 ☐ No					
	vith th	Ë	10e. Street and Number			10f. Zip Code			10	ng. Citizen of	What Cou	ntry?					
	s 23s	Funeral	502 Fleetwood St			20910				44 De	USA	and the state of					
	ltem ner n	Š	11. Marital Status 1√√2 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Ongli an, Mexican,	n? (Specit Puerto Ric	y Yes or No- an, etc.)		ck, White,	can Indian, etc.					
36	rs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specif	y: Whi	te					
215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Ed		16a. Deced	dent's Usual Occup	ation			 16b. Kind of B	usiness/In	dustry					
15	nin 72 In "na Medio	Completed	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most o d)	of working									
212	d with	E	12	College (1-401 5+)	Sec	retary				Manuf	actu	ring					
	e filed al Hygi other vent, ti	Be	17. Father's Name (First, Middle, Last)	·			18. Mother's	s Name (F	irst, Middle, N	faiden Surnar	ne)						
<u> a</u>	Mental Mental arked or	ToE	William H. Grund				Rose A	ugus	tine Va	an Land	lingh	am					
Maryland	and and Is m	ľ	19a. Informant's Name/Relationship (7		1	g Address (Street				-	, State, Zij	Code)					
	s 1 and 2 of Health Item 27 I		Karen L. Tuohey/N			Vixen La		eato	n, MD 2	20906							
altimore,	of Herr		20a. Method of Disposition 1 ☐ Burial ★ ☐ Cremation 3 ☐	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce) F	'eb. ^{Date}	12,	20c. Location	- City or T	own, State					
Ĕ	Pages ment of H ant: If Ite ury or of		4 □ Donation 5 □ Other (Specify		tropoli	tan Crem	atory	2008	AJ.	.exandr	ia,	Virginia					
alt	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licen	gnature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc.													
8	<u>⊽</u> □ = ≈ ∂		Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 2090														
Œ.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat on cause on each line.	h. Do not ente	er the mode of dyin	ng, such as ca	ardiac or re	espiratory arre	est,	3	Approximate Interval Between					
1	Physician		Immediate Cause (Final disease or condition	a Intracrania	Homor	rhage						Onset and Death days					
	/Medical Examiner		resulting in death)	Due to (or as a conseq		Luage						uays					
k.	Examiner	L	Sequentially list conditions,	b Hypertension	2							years					
	be tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	tue to (or as a conseq	uence of):												
	and trans	каш	that initiated events resulting in death) Last	c. Cerebral Ede								days					
8760,	cate be executed oblysician and the burlal-transit			Due to (or as a conseq	derice or).												
387	cate phys the	dical		d	····							-					
9 ×	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome pf pregna	ancv					201 P							
Вох	atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)	/				ate of delivonth	ery Day Year					
o.	at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	leatii 5L												
P.0	res that igned by		Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?					
sp.	uires sign Id be	d by							1	s 2∐No	3 ☐ Pro	bably 4 ⊠Unknown					
Ö	w require been signal	Completed						11.5	24a. Was ar	245	More out	ppsy findings available					
Re	The lav	m							autops perforn	y i	prior to co	impletion of cause of					
g			25. Was case referred to medical						1□ Yes 2	. ₩o	1 ☐ Yes	2□No					
₹	Sic se	Be C	examiner?	Hospital: 1 √ Inpatient 2 □	ER/Outpatien	t 3□ DOA Oth	or:		heck only one								
ō	J Physer this eral di	5	27. Manper of Death	28a. Date of Injury	28b. Time of	C 911 00X	4 LI Nurs		5 Reside			TY)					
0	Attending Firdeath. ector: After by the funer	işi İğ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2.∐No	,									
Division or Vital Records,	Atter r dea ector by th	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he	ome, farm, str	eet, factory, office		28f	Location (Str	reet and Numi	ber or Run	al Route Number,					
ā	alor a Dir	Certification:	4 Homicide	building, etc. (Specif	у)				City or Town	, State)							
	To the Hospital or Attene within 24 hours after death To the Funera Director: completely filled in by the		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	wledge, death	occurred at the tir	ne, date and	place, and	I due to the ca	use(s) and m	anner as s	stated.					
	the H lin 24 the F tplete	Medical	one)	and manner stated.	tuois and/or ins			loccurred	at the time, da	ate and prace,	and due i	o the cause(s)					
	Nit of the state o	Σ	29bcSignature and title of certifier	12		29c. Licens	e number	20	29	d. Date signe	ed (Month,	Day, Year)					
)	8		gy & run	0		103	048	T		2-11	-08	5					
	U		30. Unite and address of person who co	20 7	23a) (Type, I	29c. Licens 05 Print) 38/9	125	En.	56200	o m	0 3	0000					
			AHMED NAV		X 83	2819	rail	ner	35,00	5 "		0.00					
	Sta		FEB 1 3 20	32. Jegistrar's Signa		acht a											
	Registr	वा	1 FD T 9 70	UU REMERS I	U KO												

To the Hospital or Attending Physician: within 24 hours after death. Division of Vital Director; d in by the f To the Funeral

31. Date filed (North) State Registra DHMH 17 Rev 1/2001

OCME 2006

3

Medical

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Donna M. Vincenti, MD

Registrar's Sign

Assistant Medical Examiner

and manner stated

manh ini

(Specify) Major Road / Highway

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State) Rt 108 & Snowden River Pkwy, Columbia, MD

February 6, 2008

Could not be

30. Name and address of person who completed cause of death (Item 23a)

'2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P M February 4, 2008 6:46 Frank J. Giles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park

Jnder 1 Year | If Under 24 Hrs. Washington Adventist Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 7, 1958 New York 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min. 1⊠M 2□F 49 Director 578-76-1045 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11300 Hermitt St. 20735 U.S. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Camera Man CBS News</u> 4 Television 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Frank H. Giles Doris Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 11300 Hermitt St. Clinton, MD 20735 Venna Giles / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/12/2008 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, 21. Signatus of Funeral Service Licenses Inc. Undre Monpoo 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit and physician P.O. Box 68760 Physician/Medical as the t IF FEMALE: for use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t al or Attending Patter death. 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 极 10 3415 HAMILTON ST#1 HYAIDVILL, MD 20782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 12 FEB 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per verb 98/6 2-26-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 04:50 A M 12 Franklin February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** upper Chesapeake Medical Cenkr Bel Air, Maryland Hartora If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours 11/9/1924 Min. 1 X M 2 □ F 219-36-0323 Maryland 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Forest Hill MD Harford Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21050 USA 909 Deer Creek Church Road items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married jo, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ i Health and Menta tem 27 is marked Ann Julia Carr Charles N. Grafton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Grafton/Wife 909 Deer Creek Church Road, Forest Hill, Md 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ascension Cemetery 2/15/2008 Street, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part Liker the distase, or completions that caused the deal of shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 3 days resulting in death) /Medical Due to (or as a consequence of): Examiner Delirium Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Dementia attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9☐Unknown 9 Unknown þ σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 1 Tyes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2 \no certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 2☐ Accident 1 ☐ Yes 2 ☐ No after death | Director: | Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 3186 February 12,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. McPhail Rd Bel Air, MD JULIE TINNEY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State EB 2 6 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Edward Goetz February 5, 2008 7:50 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Devlin Manor Health Care Center Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1**∑**M 2□F 89 217-10-4173 07/30/1918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 X Yes 2 No Director MD Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or pe 'natural'', or items 23a dical Examiner must b 220 Somerville Avenue USA 21502 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No 1943 ■ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten Iny or other traumafic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Retail 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Goetz Kathleen Agnes Jenkins ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10102 Shortest Day Road, NW, LaVale, MD Linda J. Proud / Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) MD Vet Cem @ Rocky Gap 02/07/2008 Flintstone, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a, Part1, En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, ine. Immediate Cause (Final disease or condition resulting in death) MONTH **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑1 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D0054004 February 5, 2008 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NR Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Reynold 12:15^p M Greenstone February 7, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1720 Brighton Dam Road Brookeville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days M 2 F Director 092-18-6864 83 Sept. 30, 1924 New York Usual Residence of Decedent a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Brookeville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or items. r items 23a o 1720 Brighton Dam Road 20833 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 StYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced era er than "nature, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physicist Raytheon ITTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Greenstone Ethel Lena Bishoff other traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn L. Greenstone/Wife 1720 Brighton Dam Road, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 <u>Alexandria, Virginia</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John Kyle C Marry Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Prostate Cancer 15 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 1∐ Yes XXX No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within To the 29c. License number

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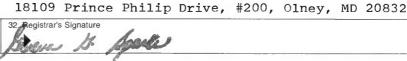
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State FEB 11 Registrar

29b. Signature and title of gertifier

Philip Henjum, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

D35045

29d. Date signed (Month, Day, Year)

February 7, 2008

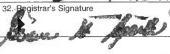
			1 - For State Registrar	State of Ma	ryland		artmen rtificat			and M		giene	008	3	0594	9
	Physic /Medi		1. Decedent's Name (First, Middle, La Howard Gerald	_{st)} Gale							2. Date of Dea Month Februal	th Day	20Ŏ	ar 8	3. Time of Dea 7:25A.	
	Examii		4a. Facility Name (If not institution, given Hillhoven Assisted Ly	g,Nursing&Reha			Adel	phi	Location o			4c. C		Geo	orge's	
	Funeral Director		5. Social Security Number 579-18-2233 Usual Residence of Decedent	Sex 7. Age	(In yrs. last	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day July29	1919	9. Pe	Birthpla Counti	y) y) ylvania	eign
	within 72 hours after death with the Maryland ene. than "nature!", or Items 23a or 28a-f ehow Ta Madical Exemirer must be notified at	ector	10a. State 10b. County Maryland Prince G		10c. City, T Greer			Code				100 Citica	1 1 A F		d. Inside City Li	
	th with 23a or	al Dir	44L Ridge Road				10f. Zip	770				10g. Citize Un	ited		•	
920	be filed within 72 hours after death with the Marylan nat Hygiene. Ind other than "naturel", or items 23a or 28a-f ehow other than "naturel", or items 23a or 28a-f ehow event. Its Madical Exemples must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Et Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		. Race - A Black, V pecify:	Vhite, et		
21215-0036	thin 72 ho e. an *natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)) _	(Give life. L		rk done d se retired,	luring most)		ng	16b. Kind	of Busine	ess/Indu	ıstry	
11 July 11	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last, Gerald Gale		′ F	rocu	remen	t Ma		r's Name	(First, Middle,	Maiden Si		Tra	nsporta	tic
aryla	should nd Mer marke	2	19a. Informant's Name/Relationship (Type, Print)	181	19b. Mailin	g Address	(Street a			h Dugua		own, Stat	e, <i>Zip C</i>	Code)	-
e, K	is 1 and 2 of Health a item 27 is other treu		William H. Gale	-son	4	4L R:	idge	Road	Gree	nbel	t, Mary	land	207	770		
Baitimore, Maryland	Pages nent of P ent: If ite ury or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif.	Removal from State	20b. Place come Metro	etery, cren poli	sition (Narr natory or of tan C	ne or ther place rema	tory		./2008	Alexa	-			а
Balt	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licer	Home) =	Do 22	nama 1d 400 P	d Address	of Facility Borgw r Mil	ardt I Ro	Funera ad Belt	l Horsvil	pe, F	A Jary	land 20	7 05
100	Pnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused to one cause on each line a. Pneumor Due to (or as a b. Due to (or as a	iia consequend	o not ente	er the mode	e of dying	j, such as d	cardiac o	r respiratory ari	est,		1	Approximate interval Between Disset and Death	
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O.	the death certifi y the attending ched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal dea		Ectopic pre Other <i>(spe</i>	egnancy ecify)				230	d. Date of Month	,	ay Year	
rds, P.		5	Part II. Other significant conditions of Diabetes CH		not resulting	g in the un	derlying ca	use give	n in Part I.						cause of death	
	The lavate has	Completed	Hypertension Dementia								24a. Was a autops perform	V	24b. Were prior death 1 \(\sum \)	to comp	y findings availabletion of cause	ible of
Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	Hospital:	2∏ EB/	Outnation	3 🗆 DO/	Other	~		(Check only on		Other (C			
Division of	I or Attending Physicien: after death. Director: After this certific i in by the funeral director,		27. Manner of Death * Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		Time of Injury		c. Injury Work		2	8d. Describe h			респу)		
Divis	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Inc.) 28f. Location (Street									Rural F	Route Number,			
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of a niner: On the basis of e and manner state	xamination	lge, death and/or inv	occurred a estigation.	it the time in my opi	, date and nion, death	place, a occurre	nd due to the cand at the time, d	ause(s) an ate and pla	d manner ace, and c	as stat	ed. ne cause(s)	
į	To the To the Comple	Me	29b. Signature and title of certifier	1200			29c.	License		-		9d. Date s				
(<i>></i>		30. Name and address of person who						-7-7-1						2008	
	Sta	te	Robyn Anderson, N 31. Date filed (Month, Day, Year)	1.D. 108	801 Los Signature	ockwo	od Dr	ive,	#205	Şi l	ver Spr	ing,	Mary	land	20901	
	Registr		FEB 1 1 20	100	. K	Dos	the s									

DHMH 17 Rev 1/2001

			For	State of		and / De	epartm		lealth a	nd Menta	Hygie	ne	
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Down The Control of the Contr	,				ale or	Dealii	2. Date Mon	of Death	No.2 18, 200	3. Time of Death 8 12:27 a M
	/Medio Examir		Dempsey C. H 4a. Facility Name (If not institution, Country Comp	give street and nu			4b. (r Location of neytow	Death	Luary	4c. County of De	
Ē	Funeral Director		5. Social Security Number	6. Sex 1 M 2 F	7. Age (In y	rs. last birth	Mon	nder 1 Year		4 Hrs. 8. Date	of Birth		irthplace (State or Foreign Country)
1	D D		412-28-3276 Usual Residence of Decedent 10a. State 10b. County			City, Town	or Location			rebi	uary	3,1943	Tennessee
	r 28a-f sh notified	Funeral Director	MD Wic	omico		Pitt	svill	e . Zip Code			10g.	Citizen of What (1 ☐ Yes 2 ☒ No
	eath with size 23a or must be	eral D	7425 Cemetery		edent Ever in	II S	13 Was D	218		in? (Specify Ves	or No.	USA	nerican Indian,
920	ours after d al", or item Examiner		1 ☐ Never Married 2 ☐ Marrie 3 【 Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 XYes If Yes, Gi Year or D	2 ☐ No ve	II		specify Cub	Specify:	in? (Specify Yes Puerto Rican, e	ic.)	Black, Wi	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+)	- "	Give kind o life. DO NO		ation during most of d)	of working	1	b. Kind of Busines State De of Highw	partment
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	Be	17. Father's Name (<i>First, Middle, L</i>	,		<u> </u> M	lechan	IIC		's Name (First, I	Aiddle, Mai	iden Surname)	ays
aryl	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	T_	Dempsey C. Hatley, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Z									, Zip Code)	
Baltimore, M			John K. Hatley 20a. Method of Disposition 1Xi Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from	State	7. Place of Connectory,	Disposition (crematory	Name of or other plac	re) Fe	nue Pit b. 22 2008	200	lle, MD c. Location - City of argitsvil	·
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service L	icensee	01	<u></u>	22. Nam	e and Addre	ss of Facility	Smith :	Tunera	al Home	26710
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a(v	caused the deach line.	eath. Do no	t enter the	mode of dyir	ng, such as c		tory arrest,		Approximate Interval Between Onset and Death
68760,	. 35	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a cons	sequence of)):		i evel	ulay A	yvsu		2007
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□F nant at time o	etal death	3 □Ectop 5 □ Othe	ic pregnancy r (specify)	/	-202		23d. Date of d	lelivery Day Year
Δ.	w requires that been signed by should be deta	by	Part II. Other significant condition	ns contributing to d	eath but not	resulting in t	he underlyii	ng cause giv	en in Part I.	23e	. Did tobac 1	4.0	to the cause of death? Probably 4 □Unknown
Vital Records,		Completed									. Was an autopsy performed Yes 2	prior t	
Vit.	9 9 9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outp	atient 3F	I DOA Oth	er'	of Death <i>(Check</i> sing Home 5		e 6 Other (S	grante
ion or	ng fte	ation: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date (Mon	<u>'</u>	28b. Tin	ne of	28c. Injur Wor	y at	28d. Des		injury occurred	Freelity Freelity
Division	i di tte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place	e of injury - A ing, etc. <i>(Spe</i>		n, street, fac	ctory, office		28f. Loca City	ition (Stree or Town, S	et and Number or State)	Rural Route Number,
	o the Hospital ithin 24 hours a the Funeral I ompletely filled	Medical	29a. Certifier (Check only one)	Physician: To the xaminer: On the b and man	e best of my l asis of exam ner stated.	knowledge, dination and/	death occur or investiga	rred at the ti	me, date and opinion, deatl	place, and due h occurred at the	to the caus	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	L				29c. Licens	e number		29d.	Date signed (Mo	nth, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21-2008 **Physician** Month_ Harold Hendershot Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1406 Piedmont Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Days Months 1**⋈** M 2□ F 201-16-4087 Mar 4, Director 81 1926 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 ust be n 1406 Piedmont Avenue 21502 "natural", or items 23a edical Examiner must ? USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 Mo If Yes, Give Year or Dates: 1944-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo Specify: Completed by Specify: 3 Widowed 4 Divorced white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i. Pages 1 and 2 should be filed within a timent of Health and Mental Hygiene. Tant: If Item 27 is marked other than "I lyury or other traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Petty Officer U.S. Navv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin L. Hendershot Ada P. (McCusker) Hendershot 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Hendershot wife 1406 Piedmont Avenue Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or Rocky Gap Veterans Cemetery 2/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Flintstone MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a; pri1. Enter the dis ase complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. Est only one cause on each line. Imm diate Cause (Final dise se or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a sonsequence Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1□ Yes 2 - No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 ☐ Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Gettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017565 Fil. 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar AT Bollins

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

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NO 21 102

lax Lee Heflin		State of Maryland / Depar - For State Certification - Certific	tment of <i>ificate</i> of		and Men	tal Hy		g. No. 200	8 05953		
Physiciar	1/	1. Decedent's Name (First, Middle,Last)				[2	. Date of Death	n	3. Time of Death		
Medical Examin	er	Max Lee Heflin 4a. Facility Name (if not institution, give street and number)					Month February 1	5, 2008	1403 hrs		
		Aa. Facility Name (if not institution, give street and number) Memorial Hospital	41	Cumberla	or Location o	of Death		4c. County of Deat Allegany	n		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Y	ear If Unde	er 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9. Bi Forei			
Director		440-56-5707 1XM 2F 54	Yrs.	Mortano	, ayo modio		March	10,1953 c	ountry) OK		
uy	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location	ก					10d. Inside City Limits		
how a	Ĺ	WV Mineral	Keys						1 X Yes 2 No		
Maryland 28a-f show any d at once.	Director	10e. Street and Number	Reys	10f. Zip Cod	e		10	g. Citizen of What Cou	intry?		
with the Maryland ns 23a or 28a-f sho be notified at once.		109 Willow Avenue		267	726			USA			
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S 1 Never Married 2 Married Armed Forces?		Decedent of			cify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,		
r deat	되	X No			No specify:		,,		hite		
urs afte	<u></u>	or Dates:	16a. Decedent				ork done	Specify: W 16b. Kind of Business			
5-0036 let within 72 hours after Aggient and content than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working	life. DO NOT	use retire	ed)	Automotive	e Component		
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		17. Father's Name (First, Middle, Last)					ne (First, Middle, Maiden Surname)				
Z = % = 5	lo Be	James Gilbert Heflin 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (S			nie Rue Cleere Rural Route Number, City or Town, State, Zip Code)				
re, MD 2 1 and 2 shou Health and 1 fitem 27 is a	- [Karen Ruth Adair Heflin/Wife	109	Willow	v Aveni	ıe	Kevser	. WV 26726	5		
imore, MD Z Pages 1 and 2 shou ment of Health and N or other traumatic	- 1	20a. Method of Disposition 20b. Pl	ace of Disposit	ion (Name of				WV 26726 20c. Location - City of	r Town, State		
Baltimore, permit. Pages 1 and Department of Heal Important. If iten injury or other tra		Dullar 2 X Cremation 3 Nemovarion State	Cumber		Cremato	ry	Feb. 21 2008	Cumberlar	id, MD		
Salti ermit. Pepartu mport	ſ	21. Signature of Funeral Service Licensee		eral Home							
	-	23a. Part I. Enter the disease, or complications that caused the death. I					Keyse		726 Approximate Interval		
Physician / Medical	ļ	failure. List only one cause on each line.						,	Between Onset and Death		
xaminer	-	Immediate Cause (Final disease or condition resulting in death) a. IMUITIPIE INJURIES Due to (or as a consequence of)	:								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED AMENDED									
876(ificate ig phy	Ě	F FEMALE: 3b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		al death	3 Ectopi	c pregnar	icy	23d. Date of delive Month	ery Day Year		
Box 6876 cath certificate the attending phy	sician/M	past 12 months? 4 Pregnant at time of dea	th -	er (Specify)							
. Bo;	2	Part II. Other significant conditions contributing to death but not res	culting in the u	dorbána cau	sa givan in D	ort I	23e Did to	obacco use contribute t	o the cause of death?		
P.O.	≥	rait is. Other significant conditions contributing to death but not res	salang in the ui	idenying cad	se given iii i	ait i.			obably 4 Unknown		
ds, Fequires equires equires ould be	Completed						24a. Was		autopsy findings available		
COT e law r e has b	휌							rmed? death?			
tal Recitian: The l		25. Was case referred to medical		26.P	lace of Death	(Check o	1 Yes	2 No 1 🗸	Yes 2 No		
of Vital Records, in Physician: The law requirement of the this certificate has been similared director, page 2 should the thin t	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ f	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5	Residence 6 Oth	er:		
fing Ph After t	ü	1 Month, Day Year)	28b. Time of In	jury 28c.	Injury at Wor	. ir		how injury occurred to in collision with	n truck		
Sior Attend r death ector: by the	ğ	Accident Investigation 28e. Place of Injury - At hor		t factory offi	Yes 2		28f Location (9	Street and Number or E	Rural Route Number, City		
Division spital or Attendir hours after death. Internal Director: A y filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road		i, laciory, on	ce building, e		or Town, S	State) north of Emily St, Ra	_		
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge		ed at the time	e, date and pl	I.					
To the Hosp within 24 hc To the Fun completely i	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated.	d/or investigati	on, in my opi	nion, death o	ccurred at	the time, date	and place, and due to	the cause(s)		
->	Šſ	29b. Signature and title of certifier			cense number			29d. Date signed (M			
		Tale Clioni-tollale	Mus		.C.M.E. 			February 16, 20	 		
12	ſ	 Name and address of person who completed cause of death (Item 2 Patricia Aronica-Pollak MD. Assistant Medical E 		111 Penn	Street, B	altimore	e, MD 2120	1			
Sta	te				,						
Registr	ar	LEDY / VIIIX Page a. At Abadelle F.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05953 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 21 Year 2008 JAMES FREEMAN HURTT, JR. 6:20p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 32762 Galena Sassafras Rd. Galena Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Nov 9 1922 5. Social Securify Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 218-20-3494 85 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 23a or 28a-f show ust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32762 Galena Sassafras Rd. "natural", or items 23a U.S.A. 21635 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked oth Be James Freeman Hurtt, Sr. Ruth M. McArthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mary Lou Hurtt (wife) 32762 Galena Sassafras Rd. Galena, MD. 21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Georgetown Cemetery 2/24/08 4 ☐ Donation 5 ☐ Other (Specify) Georgetown, MD. 21. Signal ne al Service lense 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or con Ition resulting in death) PULMONARY **Physician** a. MULTIPE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTENY DISEASE 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760, 24 hours a e Funeral I Hospital within 2

> 0 State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 Speer

We mo

122

32. Registrar's Signature

the state of the s

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Noble,

29c. License number D 0041587

Rd. Chestertown, MD. 21620

29d. Date signed (Month, Day, Year)

2008

1

amuel Hood		1- For State	ate of Maryl	and / E	•	rtment of tificate of			Menta	al Hyg		g. No.	20	08 0	595
Physicia		Registrar 1. Decedent's Name (First, Midd)	le,Last)								Date of Death			3. Time of D	Death
ledical Exami	ner	Samuel W. H	lood Jr.								Month Febr∪ary 1	_{Дау} 4, 2008	Year }	2058 h	rs
		4a. Facility Name (if not institution University Hospital	n, give street and n	umber)		41	b. City, 1 Baltin		ocation of I	Death		4c. Co	ounty of De	ath	
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	n yrs. la	st birthday)	If Unde	er 1 Year	If Under 2	24Hrs.	8. Date of Birth	(MM/DD/		Birthplace (State	e or
Director		220-54-4987	1 x M 2 F	5	7	Yrs.	Month	s Days	Hours	Min.	2 - 4 - 1	0.5.1		eign Country) M	ח
		Usual Residence of Decedent	122		<i>'</i>		<u> </u>				2-4-1	771			
any		10a. State 10b. County		10	c. City,	Town or Location	n							10d. Inside	City Limits
yland -f show once.	Ŀ	MD Fred	erick		F	rederi	ck							1 X Yes	2 No
Aaryland 28a-f show Lat once.	Director	10e. Street and Number					10f. Zip	Code			10	g. Citizen	of What C	ountry?	
he M	Pir	244 East 7th	Street				2 1	701				TT .	S A		
with 1 s 23a e not		11. Marital Status	12. Was De	cedent Eve	er in U.S	S. 13. Was			anic Origin	? (Spec	ify Yes or No-			nerican Indian, E	Black,
eath 'item	Funeral	1 Never Married 2 X M	arried Armed F	orces?	Na				Mexican, P				White, etc		
fter d		3 Widowed 4 Div	rorced If Yes, Give Ye		NO	1	Yes 2	X No	specify:			Sp	ecify: W]	hite	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	d by	15. Decedent's Education (Spe	cify only highest gra	de comple	ted)	16a. Decedent						16b. Kind	of Busines	ss/Industry	
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)		· ·			DO NOT us		1)				
036 rithin rr tha	Completed	8			_ }	Resta	ura	nt S	Stafi	f		Foo	od Se	ervice	
5-0 led w Othe		17. Father's Name (First, Middle	, Last)					18	3.Mother's	Name (F	irst, Middle, M	aiden Sui	rname)	-	
121 be fi rrked	æ	Samuel W. H									Whip				
D 21 hould hould Me is ma	٢	19a. Informant's Name/Relations				No.								ate, Zip Code)	
ME 1d 2 s alth a m 27 aum;		Samuel W. Ho	od III	S	o n							Germ	anto	wn MD 2 or Town, State	0874
ore, salan s		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal 1	rom State		lace of Disposi rematory or oth			etery,	- 1	Date	20c. Loc	ation - City	or rown, State	
Page Page nent c		4 Donation 5 Other S			Мо	unt 01	ive	t Ce	em :	2/2:	1/2008	Fre	ederi	ck, Ml	D
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa		21. Signature of Funeral Service				22. Na	ame and	Address	of Facility	Кее	ney &	Bas	ford	P.A.	F.H.
W 50 F.E.	1	philits	Kan	M01		1 1 0	6 E	ast	Chur	rc h	St Fr	eder	rick,	MD 2:	1701
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the	death.	Do not enter th	e mode	of dying, s	uch as car	diac or r	espiratory arre	st, shock,	, or heart		ate Interval Onset and
/Medical xaminer		Immediate Cause (Final disease	DI 15	e Injurie	s of H	lead and Ne	eck							D	eath
		or condition resulting in death)	Due to (or as	a consequ	ence of):								1	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	o concogu	onco of	١٠		_							
	Ë	cause. Enter Underlying Cause		a consequ	ence or	,.								- 12	
/ - =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):									-
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lox 68760, eath certificate be exe e attending physician of or use as the burial -	dical	UNPENDED	AMENDED												
6876C certificate nding phys se as the bu	Ψ,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes		of pregn				7				Date of deliv	-	
68 certif	ian	past 12 months?	I I LIVE	birth nant at tim	e of dea	-4h	al death	3 _	_Ectopic p	oregnand	^E y	I Mo	onth	Day	Year
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O. B. it the de lacked 1		Part II. Other significant condit	tions contributing	to death bu	ut not re	sulting in the ur	nderlying	cause giv	ven in Part	I.	23e. Did to	bacco use	e contribute	to the cause of	death?
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ords, w requires the second should	Completed										24a. Was a			autopsy finding	
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1-		25. Was case referred to medica						26 Diago	of Death (C	'hook on	1 Yes 2	No No	1 🗸	Yes 2	No
Ivision of Vital Records, or Attending Physician: The law require after death. Director: After this certificate has been si in by the funeral director, page 2 should b.	Be	examiner?	Hospital: 1	Innationt	2	ER/Outpatient			thor:			Residence	e 6 0	ther:	
of Vir	ပို	1 ✓ Yes 2 No 27. Manner of Death	28a, Date	of Injury		28b. Time of In			at Work?		8d. Describe h				
C = . ~ 2	Certification:	1 Natural 5 Pene	EQ(MRN)	h, Day,Year)):	'	FOUND:	· ·		es 2 🗸 N	ls.	ubject assa				
Division tal or Attendi rs after death. al Director:	ig	2 Accident Inve	stigation Feb 14			0709 hrs me, farm, stree	t. factory	, office bu	ildina, etc.	2	8f. Location (S	treet and	Number or	Rural Route No	ımber. Citv
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in G in		29a. Certifier	hysician: To the be		owleda	e death occur	ad at the	time date	e and place						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	miner:On the basis	of examin											
To To	Me	29b. Signature and title of certific	and manner	stated.			29	c. License	number			29d. Dat	te signed (Month, Day, Yea	ar)
		111. B.	(1) N	1				O.C.N	1.E.				ary 15, 2		
		30. Name and address of person	Med 111	Se of doc	h /ltem	23a)									
2		Melissa Brassell, MD	wno completed call Assistant Me				enn St	reet, Ba	altimore,	MD 2	1201				
C+	ate	31. Date filed (Month, Day, Year)		egistrar's			4								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

law requires that the death certificate be executed attending physician and for use as the burial-tran page 2 certificate this funeral

Division or Vital Records, P.O. Box 68760, or Attending Physician: safter death.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, Physician 2008 Hendrick February 14:02 Debrah Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗗 🖛 214-78-7409 48 Director July 22, 1959 Washington, DC Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☑ Yes 2 ☐ No Directo Maryland Prince George's Laure1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 United States 11700 S. Laurel Drive #2D Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Black. ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Disabled Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Hendrick Gladys Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Andre Hendrick - Son 7609 Burnside Road Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery Feb 14, 2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Diabetic Ketoacidosis /Medical Due to (or as a consequence of): Examiner Possible Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Altered Mental Status Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 912 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 [3]Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide [Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Myuney February 7, 2008 D0064760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mythily Vancha, MD 10724 Little Patuxent Parkway, Suite 200 Columbia, MD 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan		artment rtificate			and M	_	giene Reg. No.	2008	05957
	Physici /Medic		1. Decedent's Name (First, Middle, I Delores Viola Hi	•							2. Date of De Month 02	Day	Year 2008	3. Time of Death 10:49 A M
	Examir		4a. Facility Name (If not institution, g Holy Cross Hospi	tal			4b. City, To	r S	pring	3	-	Mon	ounty of Death tgomery	,
W.	Funeral Director		5. Social Security Number 6. 577 46 1397 Usual Residence of Decedent	. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	73 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir	1934	9. Birthp	place (State or Foreign ntry)
	e Maryland sa-f show tified at	ctor	10a. State 10b. County D.C.			,TownorLo							1	10d. Inside City Limits 1 X Yes 2 No
	vith the	Dire	10e. Street and Number	NII // O			10f. Zip C					_	n of What Coul	
36	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	769 Quebec Place 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced	ces? 2) No				spanic Orion, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	D- 14	ed Stat Race - Americ Black, White,	can Indian,
Maryland 21215-0036	ithin 72 hou ne. nan "natura Medical E	npleted	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	(Give life.	dent's Usual (kind of work DO NOT use are Pr	done di retired)	uring most	t of worki	ng		of Business/In	·
121	iled w Hygier Iher th nt, the	S	17. Father's Name (First, Middle, La	st)		Day C	are rr			r's Name	(First, Middle		- Emplo	yed
ylano	es 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than "ir other traumatic event, the Med	To Be	William Leray H						_	_	E. Wat			
Mar	nd 2 shoulth and 27 is mark		19a. Informant's Name/Relationship Dorthea Bradley	(Type. Print) Daugh	ter	1	-					-	own, State, Zip Land 20	*
Baltimore,	Pages 1 ar ment of Hea ant: If item ary or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		itale	lace of Dispo emetery, crei	sition (Name matory or othe	of er place	9)	С	ate	20c. Loca	tion - City or To	own, State
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of FacilityJohn T. Rhines Funeral Home, I 3005 12th Street NE Washington, DC 20017											
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio-Respiratory Arrest Due to (or as a consequence of):												Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Severe	Dehyd:	ration					-			
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	Ideath 3[Ectopic preg Other (spec					23	d. Date of deliving Month	ery Day Year
rds, P.	w requires that been signed t should be det	by	Part II. Other significant conditions Chronic Kidney			ulting in the u	nderlying cau	se give	n in Part I.		23e. Did t			he cause of death? bably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		ED/0.4		Othe	r		(Check only o			
ō	ing Affe une	ıtion: To	1 Yes 27 No 27. Manner of Death 17. Natural 5 Pending 2 Accident investigat	28a. Date o		ER/Outpatier 28b. Time o Injury		: Injury Work	4 L Nu	2	ne 5∐ Resi 28d. Describe		Other (Special	fy)
Division	tal or Attend s after death at Director; , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not determine	A ZOC. FIACE	of injury - At hog, etc. (Specif	ome, farm, str	eet, factory, o	office		2	28f. Location (City or To		Number or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical (29a. Certifier 1 A Certifying (Check only one) 1 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	wledge, deat tion and/or in	vestigation, in	n my op	inion, dea	d place, ath occurr	and due to the ed at the time,	, date and p	lace, and due t	to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	Maya	& m) .	D6	icense	number 9				signed (Month, 8/2008	Day, Year)
1	-(3)		30. Name and address of person wh						M	1rv1	and 200	10		
	Sta Registi		Nama Tanag, MD 15 31. Date filed (Month, Day, Year) FEB 1 2 2008	32. Re	egistrar's Signa	Ka. Si	_iver S	pri	ng, ric	** y 1.c	u 209	10		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** A^M Alfred Zebedee Haines February 12, 4:08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Ceci1 Union Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 173-07-3092 91 March 21, 1916 New Jersey Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 682 Telegraph Road 21911 Funeral 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 Farming Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be William Herbert Haines Hanna Cope ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Summers Lane, Rising Sun, MD 21911 Elizabeth Warrington/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2-16-2008 1 X Buriat 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) West Grove Friends Meeting West Grove, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. It s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as deprovated in the state of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approvate on each line. ich and Part. Enter the disease, or complicati shock, or heart failure. List only one Approximate Interval Between Onset and Death or complication Immediate Cause (Final disease or condition resulting in death) **Physician** 010 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any had including to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the hurial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar one)

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31. Date filed (Month)

and title of certifie

29b. Signatur

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Name and address of person who completed cause of death (Item 23a) (

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Day, Year)

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	State of Maryland /	Department of He	salth and Me	antal Hygieni
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Christ	opher Hells			ate of Maryla	and / Depar	rtment of	Health and	Mental	Hygiene	21	08 059		
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	arylan 8a-f	쉾	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?		
	the M a or 2 tifted	ä	32 Crestwo	od Dr			2192	21		U.S.			
	n with the Maryland nis 23a or 28a-f show he notified at once.	<u>ra</u>	11. Marital Status	12. Was De	ecedent Ever in U.S Forces?	S. 13. Wa	s Decedent of His	panic Origin'	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,		
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	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked offer than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Max Hellste	rn, Sr.	/Father		Crestwo		r., Elkto	n, MD 20c. Location - City	21921		
	e, e, land land Healt item		20a. Method of Disposition 1 X Burial 2 Crematio										
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	Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		21 Signature III neral Service	e Licensee		emerce,	And row	s of Facility	ee Funera	1 Home			
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A.	Physician		failure. List only one cause	e on each line.				r, such as car	triac or respiratory aire	sat, shoek, or healt	Between Onset and Death		
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	cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2, should be detached for use as the burial - transit	dical	UNPENDED	AMENDE	D								
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	sior trend death ctor:	Natural 5 Pending Investigation 2 Accident 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street 2 Pending Investigation 2 Pendin								Street and Number	or Rural Route Number, City		
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	the II hin 24 the Fi	lical	one only	xaminer:On the ba	sis of examination	and/or investig	ation, in my opini	on, death occ	curred at the time, date	e and place, and due	to the cause(s)		
•	To To	Medic	29b. Signature and title of cert	and mann	A		29c. Lice	nse number			(Month, Day, Year)		
			1/1/01	luloss	W		0.0	C.M.E.		February 8, 2	2008		
			30. Name and address of pers	on who completed	cause of death (Ite	em 23a)							
			Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
		State		2008	2. Registrar's Signa	ature	W						
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Division or Vital Records, P.O. Box 68760,

		For State	State of Mar	yland / [•			Mental F	lygien	е				
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Funeral	7	5. Social Security Number 6. S	rthday)	If Under 1 Year Months Days		s. 8. Date of	Birth Day, Year			lace (State or Foreign				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or tems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify		Ceme	eter	у	14	, 2008	Co1	ora,	Mary	1and		
Depared Important In any Ir		21. Signafore of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901												
	Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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/Medical Examiner		resulting in death) Due to (or as a consequence of):									4.			
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o the		29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year)										
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+IVA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
	Neil E. Cottin, MB OU COCONINE Way, KISING SIN (MI) SHALL													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

3. Time of Death

Physician /Medical

Examiner 4a. Facility Name (If not institution, give street and number)			street and number)	4b. City, Town, or Location of Death				4c. County of Death			
	LXamii	iei	Johns Hopkins Hospital Baltimore								
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 221–20–3786 74 Yrs.			If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 5			y, Year) 1933 Wilmington		
Baltimore, Maryland 21215-0036	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Delaware New Ca		Town or Local					10d. Inside City Limits	
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	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Maxical Extendent mark be netiting at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	If Yes Give		S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				ace - American Indian, ack, White, etc. ify: White	
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	1 and 2 sho Health and tem 27 le m		19a. Informant's Name/Relationship (Ty Dorothy Haggerty (daughter)	204 Pr	iscilla		Lewes, D	E 199		
	Page nent o ant: If ury or		20a. Method of Disposition 1	emoval from State	verbroo	k Cemet	ery Feb	11 2008	Wilm	ington, DE	
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Records, P.O. Box 68760,	Physician /Medical Examiner	Examiner	23 Part1 Inter the disease, or complishood, or heart failure. List only or Imm. late Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).	Fa.74 ence of): ence of):		ng, such as cardiai	c or respiratory arre	sst,	Approximate Interval Between Onset and Death 2 weeks 1 month	
	uires that the death certificate be executed signed by the attending physician and deedeached for use as the burial-transit	y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1	death 3 ☐ E ath 5 ☐ C	ctopic pregnanc hther (specify) erlying cause giv		23e. Did tob	٨	Date of delivery Month Day Year Intribute to the cause of death?	
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)	To t To t	Σ	29b. Signature and title of certifier	Kemp MD		RES	S - 000) P	ebrug	ned (Month, Day, Year) y 4, 2008	
	10		30. Name and address of person who co	mpleted cause of death (Item		wolfe	Street	Balton	ore n	D 21287	

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State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Melvin Harris 2,2008February 12:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Community Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 🗆 F 253-46-2079 Director 67 March 14,1940 Georgia Usual Residence of Decedent Maryland 10c. City, Town or Location r 28a-f show notified at 10a State 10d, Inside City Limits Director 1 Yes 2 No DC None Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or death with 5051 Hayes Street, N.E. 20019 Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ₺ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Handyman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown 2 Mamie Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health an Important: If item 27 is many injury or other Betty Holman - Stepdaughter 1606 Marblewood Ave., Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 02/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. Riverdale, MD 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee 3831 Georgia Ave., NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Caronary Artery Disease Sequentially list conditions Due to (or se a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Hypertension Due to (or as a consequence of) physician Congestive Heart Failure Physician/Medical the as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated. the To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause

13

Day, Year)

FEB

31. Date filed (Month

3001

2008

DHMH 17 Rev 1/2001

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altimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

heverly MD 20785

eath (Item 23a) (Type, Print)

HOSPITA

Mistrar's Signature

2-5-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 10 Day 200 8 Par FEB. 7:28P **Physician** MAURICE W. HAYES SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES OXON HILL 2113 ALICE AVE #104 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 8/24/47 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Hours Days **Funeral** Months 1**X** M 2□ F TENNÉSSEE 60 414-80-1384 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marked 10c. City, Town or Location 10a. State 10b. County 1 √Yes 2 No Directo PRINCE GEORGES OXON HILL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 20745 2113 ALICE AVE. #104 Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1965-Black, White, etc. 11 Yes 2 No 11 Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: BLACK 1969 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) VERIZON SERVICE TECHNICIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SADIE MAE HADLEY JAMES HAYES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2113 ALICE AVE#104 OXON HILL,MD 20745 PATRICIA M. HAYES/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State CLINTON, MD RESURRECTION CEM. 2/21/08 4 Donation 5 Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service Licenses 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 towns emia Approximate Interval Between Onset and Death 23a. Part. Ent. (Ih) disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1YEAR COLON CANCER-METASTATIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 3□ DOA 2 ☐ ER/Outpatient 1 Inpatient 1 ☐ Yes 2 X No 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury 1 XNatural 5 Pending investigation To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

the death certificate be executed and burial-trar nding physician the as use ρ ned by the a signed b peen page 2 s certificate After or Attending

Division or Vital Records, P.O. Box 68760,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide 4 Homicide

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year) 726.15,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERBERT WASHINGTON, MD 11701 LIVINGSTON RD. #205 FT. WASHINGTON, MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

FEB 15



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear 6:30 P 5 2008 Viveca Lynn Higgins February 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Frederick Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours Months Days 1 □ M 2 🕅 F 59 Sept 4, 1948 212-54-5242 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 USA 812 Ivy Way #1B 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 🎇 No Specify Specify: White 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Daycare Daycare Provider 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Jackson Saunders Lillian Mae Ormdandy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peter M. Higgins/husband 812 Ivy Way #1B Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 02/09/08 Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signate of Funeral Service Licenses Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. huptica officer supplement dependence une to (or as conservence of): unserstitut lun disease or condition resulting in death) non-metastation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner sician and burial-tran

Physician

/Medical

Examiner

Director

Funeral

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Completed

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show

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

death

permit. Pages 1 and 2 should be filed within 72 hours after constraint. If item 27 is marked other than "natural", or therrany injury or other traumatic event. the unitary or other traumatic event.

Examiner physician s the buria Physician/Medical ned by the attent detached for u Completed by Be Certification: To within 24 hours after death.

To the Funeral Cirector: Affer thi
completely filled in by the furieral

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

2[**X** No 1 ☐ Yes

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

00065201

29c. License number

29d. Date signed (Month, Day, Year)

21703

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7190 CRESTWOOD BLUD

State Registrar

Medical

BERG, MD 32. Projistrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9, 2008 10:00 P.^M February Leroy B. Hooper /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Lusby Calvert 331 Geronimo Road 8. Date of Birth (Month, Day, Year) 09/27/1934 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Maryland 217-32-0872 73 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 No Director MD Calvert Lusby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or ? must be n 20657 United States 331 Geronimo Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1961 14. Race - American Indian ral", or items 2 Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Automobile and the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Utility Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leila Virginia Buck John Wesley Hooper ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 331 Geronimo Road, Lusby, Maryland 20657 Jean M. Hooper (Wife) If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once, Trinity Mem. Gardens 02/13/2008 Waldorf, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Aortic valve disease - aortic stenosis Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician End stage renal disease Physician/Medical attending properties for use as If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 TYes 2□ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification; 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

120

David J. Tardio, MD 14090 Solomons Island Road, Suite 2500, Solomons, Maryland 20688 31. Date filed (Month, Day, State 1 Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SS

February 11, 2008

			1- State of Marylar State of Marylar		artment of H rtificate of I			giene Reg. No. 20	108	05966
	Physic		1. Decedent's Name (First, Middle, Last) Robert Waugh H		Date of Death Month Day Year			3. Time of Death		
	/Medi Exami		4a. Facility Name (If not institution, give street and number)	lamilto	4b. City, Town, or		1	4c. County		6:50a [™]
	Funeral Director		10123 Dallas Avenue 5. Social Security Number 579-01-0305 6. Sex 1 M 2□ F 85	. last birthday) Yrs.	If Under 1 Year Months Days	ilver Sp If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year) 3. 1922	9. Birthplac Country Mary	ce (State or Foreign
	/aryland f show ed at	or		ity, Town or Lo					10d	1. Inside City Limits 1 □Yes 🛠 🙀 No
21215-0036	with the Na or 28a-	I Director	Maryland Montgomery 10e. Street and Number 10123 Dallas Avenue	Silv	er Spring 10f. Zip Code	0901		10g. Citizen of V	What Country	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in L Armed Forces? 1 □ Never Married 12. Was Decedent Ever in L Armed Forces?		Was Decedent of H If Yes, specify Cuba		pecify Yes or No o Rican, etc.)		e - American ck, White, etc	
	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Mediral Exa once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wor)	king	16b. Kind of Bu	n Elect	tric
Maryland 2	ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) George Robert Hamilton	_ supe.	rvisor	18. Mother's Nan	ne (First, Middle,			<u> </u>
	and 2 sho salth and I 27 is ma er traums	·	19a Informant's Name/Relationship (Type Print) Marine Hamilton/Wife		ng Address (Street a					
Baltimore,	Pages 1 ment of He ant; If iten ury or oth		A Dania E Dotemation o Ditemoval from State		esition (Name of matory or other place ans Cemet	1		20c. Location -	•	n, State Maryland
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	F1	Name and Address rancis J.	Collins	Funeral	l Home I	inc.	
68760,	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only be cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myccardial Due to (or as a consection)	Infaro		g, such as cardiac	or respiratory a	rrest,		pproximate oterval Between onset and Death
	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, law, leading to find out to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection).	quanea of):	Heart Dis	ease			20) Years
O. Box	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of co	al death 3 □	Ectopic pregnancy Other (specify)			23d. Dat	te of delivery nth Da	ay Year
rds, P	w requires that the debeen signed by the should be detached	5	Part II. Other significant conditions contributing to death but not res Atrial Fibrillation	ulting in the ur	nderfying cause give	n in Part I.		obacco use contr Yes 2 No		cause of death?
Il Records,	The lay ate has page 2	Completed					24a. Was autor perfo 1∐ Yes	osy prmed?	Were autopsy prior to compl death?	y findings available letion of cause of
r Vit	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 △ Yes 2 □ No Hospital: 1 □ Inpatient 2 □	ER/Outpatien	t 3 DOA Othe	26. Place of Dea		one) dence 6 □Otho	er (Specify)	
Division or Vital	ling After funer		27. Manner of Death XB Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work			now injury occurr		
Divis	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At h building, etc. (Specin	Street and Number vn, State)	eet and Number or Rural Route Number, State)					
	the Hospital hin 24 hours a the Funeral mpletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot 2 Medical Examiner: On the basis of examina and mainer stated.	wledge, death ation and/or inv	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as state and due to th	ed. le cause(s)
	DX/	2	29b. Signature and the of certifier Chamber 1	UD	29c. License	524	9/	29d. Date signed	(Month, Day	y, Year) 8, 2008
	(-		30 Name and address of person who completed cause of death (Iten	1 23a) (Type, F	ockwood	Drive !	Silver	Pprima	MD	20901
C	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 1 1 2008	iture	150	J			,	

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02706/2008 11:30 p M /Medical Susan Marie Hankins 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11516 Ropeknot Road Lusby Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 21 F Months Days Hours 05/12/1946 215-44-2659
Usual Residence of Decedent 61 Washington, DC Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show or items 23a or 28a-f shov miner must be notified at 1 ☐ Yes 2 No Director MD Calvert Lusby 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20657 U.S.A. by Funeral 11516 Ropeknot Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural", or item any injury or other transment. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work <mark>done</mark> during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Jean Marie Herbert Gordon Maxwell Weatherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Hankins - Son 12140 Pinetree Lane, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 02/13/2008 Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Ligensee 8125 Southern Md Blvd., Owings, MD 20736 M. Mounts Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequence of) burial Box 68760 signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I 1 🗆 Yes 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page performe 2 No rector, Was cas 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2□ No 1 res 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work? M 1 ☐ Yes 2 ☐ No Certification: After 5 ☐ Pending investigation 1 Natural To the Hospital or Attend within 24 hours after death. To the Funeral Director; 2 ☐ Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and ad

Stephen

31. Date filed (Month, Dav. Year)

Cafferty

2 2008

D.O.

DHMH 17 Rev 1/2001

22333 Greenview Parkway 5A, Great Mills, MD 20634

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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-01296 atherine L. Hunt	Please Type or Print in Black Indelible Ink. Ens State of Maryland / Department of Health	are All Copies Are Legible. and Mental Hygiene	
	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No.	Year 1045 bro
edical Examiner		g	ounty of Death gany
Funeral Director	215-26-6323 1 M 2 F 79 Yrs.	Year If Under 24Hrs. 8. Date of Birth (MM/DD/Days Hours Min. 10 - 24 - 192	9. Birthplace (State or Foreign Country) MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 X Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oct during most of workin Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Oct during most of workin HOMEMAKER 17. Father's Name (First, Middle, Last) G. RAYMOND LOAR 19a. Informant's Name/Relationship (Type, Print) LINDA HUNT DAUGHTER 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	3 2 UNITI If Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) No specify: Specify: Supation (Give kind of work done glife. DO NOT use retired) 18. Mother's Name (First, Middle, Maiden Su MARGARET HOWELL L Street and Number or Rural Route Number, City CFIELD RD BALTIMORE of cemetery, Date 20c. Loc REMATORY2-16-08 CUM dress of Facility SOWERS FUNER	or Town, State, Zip Code) MD 21222 cation - City or Town, State BERLAND, MD
Physician /Medical :aminer	Alan M. Sowers per dvr 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Card Due to (or as a consequence of):	MAIN ST FROSTBURG, lying, such as cardiac or respiratory arrest, shock	MD 21532
ed nisit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		
in of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and timeral director, page 2 should be detached for use as the burial - rander of the Committed by Physician/Medical	AMENDED 21 per fh g8/6 2–26 3	3	nce 6 🗸 Other: Scene
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	2g. Certifying Physician: To the best of my knowledge, death occurred at the confection one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	ppinion, death occurred at the time, date and plan License number 29d. E	Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, B.	0.0111112	ruary 15, 2008
Stat	ite 31. Date filed (Month, Day, Year) 32. Togistrar's Signature		
DHMH 17 Rev 1/200 OCME 2006	and a state of the		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d per dr., g876 024/251/08dbbath Day 9 Decedent's Name (First, Middle, Last) 2. Date of Death February Month Year Physician E. HUTCHISON 2008 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDE BURNIE BALTIMORE WAShington Medical Center GLEN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)

MARYLAND 5. Social Security Number **Funeral** Days 215.32.8918 1 M 2 □ F Months Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 No Director EVERN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21144 1931 STONE Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. "natural", or iten edicai Examiner permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 2 No ShiTE 1 Tyes Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S.ARMY 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dellie Hotchison, 20a. Method of Disposition 2186 SEVERN MD. 21144 Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARLWATON NATIONAL CEM-4 ☐ Donation 5 ☐ Other (Specify) if u ral Service Lice see 21. Signay Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Approximate Interval Between Part 1. Enter the dise shock, or heart failu r complications the sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nset and Death Immediate Cause (Final disease or condition resulting in death) a mui (**Physician** anoxic encephalopethy /Medical Due to (or as a consequence of) Examiner carolice gures Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Mear Coronary unley the death certificate be executed and -tran Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, on dialysis, discare 3 Probably 4 Honknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
1□ Yes 2 No has e 2 page After this certificate funeral director, pag or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year)
February 9, 2608 29c. License number 29b. Signature and title of certifier D00924F completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Hospital Dr. Glan Burnie, Mb 2106/ 10 lacubs nun 305 STUGFT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 2 5 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A M 20 2008 0635 Raymond Lester Jones February /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Manor Healthcare Center Rising Sun

| Under 1 Year | | Under 24 Hrs. |
| Wonths | Days | Hours | Min. Cecil 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F March 29, 1920 87 Pennsylvania 213-16-9860 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d, Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Director Rising Sun Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21911 United States 400 Mount Street Funeral 12. Was Decedent Ever in U.S.
Armed Forces? World
1 ☑ Yes 2□No
If Yes, Give
Year or Dates: War I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No Maryland 21215-0036 Specify: War II þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 27 is marked other than "natu er traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Textile Manufacturing Plant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Jones Myrtle Burkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 48 Vineyard Drive, Port Deposit, MD 21904 Ray W. Jones/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham 4 Donation 5 Other (Specify) 2008 Colora, MD Presbyterian Cemetery 25, 2008 | Colo 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 3□ DOA 2 ER/Outpatient P this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Funeral Director letely filled in by t determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the d title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature ٥

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Registrar

State

31. Date filed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a) (Type, Print)

2008

FEB 2

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland Registrar				/lental Hyg	iene	
				Cer	tificate of l	Death	T	eg. No.	18 05973
п	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Y	ear M
A.C.	/Medic		David William Jump 4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death	Februar	y 8, 200 4c. County of	
1	Examin	er	1208 E. Patuxent Drive		La Plat			Char1	
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign
b	Director		286-05-2578 1 ¹ 2□F 90	Yrs.	WOTHITS Days	Hours Willi.	March 2		Country) Ohio
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Loc	cation			<u></u>	10d. Inside City Limits
	Maryll f sho led al	or	MD Charles	T - D	11				1 1 Yes 2 □ No
	the 28a-	rect	10e. Street and Number	La_P	lata 10f. Zip Code		1	0g. Citizen of Wh	at Country?
	h with	I D	106 Thomas Jefferson Street		2064	6		USA	
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race -	American Indian, White, etc.
9	after or ite	/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		☐Yes 2☐No	Specify:	riidari, etc.)	Specify:	White
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	Widowed 4 □ Divorced Year or Dates:			_41			
15-	n 72 I "nat Iedica	Completed	(Specify only highest grade completed)	(Give k	ent's Usual Occup: kind of work done o OO NOT use retired	during most of work	king	16b. Kind of Busi	ness/industry
12	withi iene. r thar	mo	Elementary/Secondary (0-12) College (1-4or 5+)		tail Sale	•		Clot	hing
D	filled Il Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I		
ılar	uld be Venta rrked ric ev	To B	Otto Vernon Jump			Lula E	Be11		
Maryland	2 sho and I Is ma	•				and Number or Rui			ate, Zip Code)
	and leaith m 27 hertr		Margaret Peterson/Daughter			uxent Dri			20646
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	3	1M Burial 2 Cremation 3 D Removal from State	netery, crem	sition (Name of natory or other plac	e) ¦		20c. Location - Ci	
∄	it. Partitude intrant injury		4 □ Donation 5 □ Other (Specify) Mary 21. Signature of Funeral Service Licensee , MOO945			Cem. 2/2		Cheltenh	ıam,MD
\mathbf{B}	permit Depar Impor any Ir once,	. ,	11 11 51 01	I A	REHART-E	ss of Facility CHOLS FUN	ERAL HON	Æ,P.A.	9
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	II St Ma er the mode of dyin	a ry's Ave ig, such as cardiac	or respiratory arr	ita,MD 2 est,	20646 Approximate
ä	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	A4	ac 14				Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent of the	nce of	F 19				years
į.	Examiner		Sequentially list conditions b.						_1
-	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or Injury	nce of):					
_	xecute and I-tran	xam	that initiated events resulting in death) Last c Due to (or as a consequent)	nce of):					
8760,	ficate be executed g physician and is the burial-transit	ia E		,-					
687	ificate g phys	edical	0.						
ŏ	h cert	Z.	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Ectopic pregnancy			23d. Date	of delivery
P.O. Box	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of deat		Other (specify)			Monti	h Day Year
<u>Р</u> .	nat the d by ti etach	Phy	9 LTORKHOWN		4-4-4	on in Dod I	ODe Did to	haasa waa santiih	usta to the same of death?
ds,	ires the signeral labe d	þ	Part II. Other significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions.	•	denying cause give	en in Parts.	1 XY		ute to the cause of death?
Ö	requ been should	eted	1				-		
Re	2 8 2	Completed	100712 5 74NOJIS				24a. Was a autops perfori	sy prie	ere autopsy findings available or to completion of cause of ath?
ta	ificate		25. Was case referred to medical			26. Place of Deat	1□ Yes	2[Z No 1]]Yes 2□No
>	Physician: r this certificanal director, I	o Be	examiner?	R/Outpatient	3 DOA Othe				Sehvers House
0	ng Ph ter th	L iu	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun Worl			ow injury occurred	
<u> </u>	endir eath. or: Al	atic	2 Accident investigation			Yes 2□No			
Division or Vital Records,	or Att fter de Nrect	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, <i>s</i> tre	et, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	pital ours a eral [29a. Certifier 1 Certifying Physician: To the best of my knowle	edae death	occurred at the tin	no, date and place	and due to the e	auso(s) and man	par as stated
	24 hc 24 hc e Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examination one) and in anner stated.	n and/or inv	estigation, in my o	pinion, death occu	rred at the time, o	late and place, an	d due to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	_	29c. License	e number	2	9d. Date signed ((Month, Day, Year)
			1 5 5	/}	000	33426		2/11	108
-	24		30. Name and address of person who completed cause of death (Item 23	3a) (Type, F	Print)				
1	DD 169		Larry Jenkins, M.D. 111 La Grang			ta,MD 20	0646		
	Sta Registr	1.3	31. Date filed (Month, Day, Year) FEB 1 1 2008	x de	rever				
			I FD T T FOOD						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

	1 - State Registrar						
·	1. Decedent's Name (First, Mide	de, Last)					
Physician /Medical	NATH	IANIE					
Examiner	4a. Facility Name (If not institution	o <i>n, giv</i> e s					
	Saint Thomas M	ore					
Funeral	5. Social Security Number	6. Sex					
Director	249-64-9491						

6:10P NATHANIEL EDWARD JENKINS. JR. February 12. 2008 cility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death int Thomas More NH / Rehab Center Prince George's Hyattsville 8. Date of Birth (Month, Day, Year)
Jan. 26, 1941 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) ial Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 → M 2 □ F Months 67 South Carolina 9-64-9491 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 √Yes 2 No Directo District of Columbia Washington 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3334 Clay St., N.E. 20019 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after de Il Hygiene. other than "natural", or item Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver/ Dispatcher 12 should be filed what and Mental Hygie. Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Edward Jenkins, Sr. Evalou 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 Is any Injury or other trau once. Jenkins, Daughter 3212 Sycamore Lane, #202, Suitland, MD 20746 Veneissa 20b. Place of Disposition (Name of cemetery, crematory or other p Riverdale Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/2008 4 □ Donation 5 □ Other (Specify) Riverdale. MD Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Jordan Funeral Service. Inc. FINN GLAINE 4001 Benning Rd., N.E., Washington, DC 20019 BUNFON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Thyroid Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Atherosclerotic Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hypertensive Cardiovascular Disease physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: the Hospital or Attending in 24 hours after death. the Funeral Director; After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 14, 2008 D051122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20782 Hyattsville, MD Juanitez 4922 Lasalle Road, Esmerando 31. Date filed (Month, Day, Year) State 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician Medical As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As City, Town or Location of Death As Facility Name (if not institution, give street and number) As City, Town or Location of Death As Facility Name (if not institution, give street and number) As City Town or Location of Death As Facility Name (if not institution, give street and number) As City Town or Location of Death As City Town or Location As City Town or Location August 14,1933 Columbia, State 10c. Columb		1 - For State Registrar	State of Mary		artment of F			lene 2008	0597
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10. Seals 10. County 10. City Tome of Location 10.	Director	250-42-4228	C++ -C-				. (Month, Day,	Year) Co	
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Sementary/Secondary (0-12) College (1-4of S+) Teacher Teac	be notified	10e. Street and Number		DIIVEL D	10f. Zip Code		10		ountry?
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19 Fasher's Name (First, Medice, Last) 19 19 19 19 19 19 19 1	r then the Market Marke	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	ation during most of wo	orking	_	
198 Informatics Name/Relationship (Type, Print) 190 Malling Address (Street and Vumber of Name And Number of Name And N	ked ott	17. Father's Name (First, Middle, Last)	Brown Sr.						
Sequentially list conditions and address of Pacility Johnson & Jenkins Funeral H	27 is ma 27 is ma r trauma	19a. Informant's Name/Relationship (7	** *	1				•	and the second
22. Name and Address of Facility 23. Signature/of Funeral Service Licenses 22. Name and Address of Facility 23. Signature/of Funeral Service Licenses 24. Name and Address of Facility 25. Name and Address o	0	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other place	(e)	Date 2	20c. Location - City or	Town, State
23a. Part I. Enter the disease, or complied from the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; Immediate Cause (Final Mode) one-time on each fine. Modical admining resulting in death) Sequentially list conditions, cause, Enter Underlying Cause (Disease or Injury 1999 (Cause Departm Imports any inju once.			22	. Name and Addre	ss of Facility	Johnson &	Jenkins Fu	neral Ho	
FFEMALE: 23c. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	Medical kaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Antino Sc Due to (or as a cor Due to (or as a cor c.	nsequence of):	er the mode of dyin	ig, such as cardia	ac or respiratory arre	SEAST	Approximate Interval Between Onset and Death
1 Yes 2 No 3 Probably 4 2/m	d by the attending physicie letached for use as the bur Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3 ☐ of death 5 ☐	Other (specify)		23a Did tob	Month	Day Year
28a. Date of Injury at Month, Day Year) 28b. Flace of Injury - At home, farm, street, factory, office 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 29c. Cartifler (Check only one) 28c. Place of Injury - At home, farm, street, factory, office 29c. Cartifler (Check only one) 28c. Place of Injury - At home, farm, street, factory, office 29c. Cartifler (Check only one) 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury	E & E								
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	urs effer d aret Direct illed in by	4 Homicide determined	building, etc. (Sp	pecify)			City or Town,	, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the Fune ppletely f	one)	iner: On the basis of exar	knowledge death nination and/or inv	estigation, in my of	oinion, death occ	urred at the time, da	ite and place, and due	to the cause(s)
2) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOTHOTOA M 20814	Yeit con	29b. Signature and title of certifier	m		29c. License	3027	- 29	-	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2)	30. Name and address of person who c	600 OLD 6	sculbut a	wn PD	Borne	FDA M	D 208	4

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JOSEPH, CAROLYNOS/08/08 2116

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Physician Robert P. Jackson Feb. 14 2008 4c. County of Deeth 3:30p.m /Medical 4b. City, Town, or Location of Deeth 4e Fecitity Name (If not institution, give street and number) Examiner Westernport
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Alleg. Nursing Home Moran Manor 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1√2 M 2□ F Days Months Yrs. 236-44-7060 Director 7-30-1930 Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item 23 or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a State 10c. City. Town or Location 10b. County 1√2 Yes 2□ No Director Alleg. Westernport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 502 Maryland AV. 21562 by Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1½ Yes 2 D No If Yes, Give Yeer or Detes: 1 9 5 3 - 5 5 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Frank F. Jackson Nannie Gannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Betty L. Jackson wife 502 MD. Av. Westernport, 20b. Place of Disposition (Name of cametery, crematory or other place)
St. Peter's Cemetery 2/18/08 Westernport, MD 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21, Signature of Funeral Service Licenses Fredlock Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errist, shock, or heart failure. List only one cause on each line. 26750 proximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) and stace KW5 Examiner Due to (or es e consequence of) Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Saknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy 1 Yes 202No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Suursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 1€ this 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending 1º Naturel 1 Yes 2 No within 24 hours aftar death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) end manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie カンロンセタ YA 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8 Jesus Tan Broadway St Frostburg, MD 21532 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State FEB 1 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles A. Jones February 2008 2:55 P 6. /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Solomons Nursing Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 71 Yrs. Director 217-32-4526 November 9, 1936 Maryland Usual Residence of Decedent death with the Maryland 10a. State r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert 1 ☐ Yes 2 No Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be 8424 Sailboat Lane 20657 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after de il Hygiene. other than "natural", or item Black, White, etc. ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Construction Cement Finisher permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Calvin Jones Beatrice Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Foote - Daughter P.O. Box 1051, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Southern Mem. Gardens Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladip Sewell Funeral Home, PA, 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical r as a consequence of); Examiner nagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or a a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Records, P.O. Box 68760, physiciar Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy detached for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably → Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Vital Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending

24 hours after death Puneral Director: filled in by the Hospital To the

ku)

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) Rd Suite 310 Prince Frederick

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:00 AM 2/19/2008 William Walter Kantz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 12 M 2□F 081 - 58 - 5091 4-2-1959 48 N.Y. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 137 East 6th Street 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event the Manal Linux or other traumatic e Elementary/Secondary (0-12) College (1-4or 5+) of United Way Non Profit Org. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward W. Kantz Catherine Zacny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Kantz Wife East 6th Street Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State 2-21-2008Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem. 22. Name and Address of Facility Keeney & Basford P.A. 21. Signature of Funeral Service Licensee Jainelle Kren MO1222 106 East Church St. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: cate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 🗌 Yes 2 □ No death. 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reet Frederick, MD Han KOh 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alexandria M. Kowalczyk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 9, 2008 **Medical Examiner** 1133 hrs Alexandria Mary Kowalczyk 3 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rt. 27 @ Albert Rill Road Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 213-33-2067 May 13 1991 Country) 2 X Yrs М MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No MD Carroll Westminster death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 293 Pleasant Valley Road <u> 21158</u> Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. If Yes, Give Year White Widowed Divorced Yes 2 X No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 10 Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kowalczyk Kathv Krammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Krammer/mother <u>293 Pleasant Vallev Road</u> Westminster MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State mportant: Department Other Specify. Joseph Cemetery 02/14/2008 Taneytown. Donation 5 21. Signatur ce License Principal Affine Fally Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part L. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** the attending physician ed for use as the burial Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 1 Yes 2 No 9 ✔ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✓ Yes 2 1 🗸 Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 examiner? DOA ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 1 🗸 Yes 2 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Feb 9, 2008 Driver auto auto collision 1128 hrs 1 Natural Yes 2 V No Pending 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Rt. 27 @ Albert Rill Road, Westminster, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJZ lincouti, MiD. O.C.M.E. February 10, 2008 MI 10 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD

Registra

ORIGINAL

32 Registrar's Signature

2008

31. Date filed (Informing Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 9, Roy Elmer Kinna Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick 8. Date of Birth Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 1927^{Country)} MD 6. Sex 7. Age (In yrs. last birthday) Days 1 X M 2 □ F 219-20-3280 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Frederick MDMiddletown 1 Tyes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Lombardy Dr. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1945 If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: White þ 1946 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance supervisor eyeglass co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy E. Kinna Elsie J. Shafer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Kinna III (Son) 10996 Horseshoe Dr., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition □Cremation 3 □Removal from State 1 X Burial Reformed cemetery 2/13/2008 Middletown, MD 5 Other (Specify uneral vior Licer 22. Name and Address of Facility Donald B. Thompson Funeral Home Sign te o 0. Box 18, Middletown, MD 21769 r the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ZHEIMERS DEMBNTIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

or Attending Physician: The law requires that the death certificate be executed Exami physician and is the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical 38 attending properties for use as Completed by s certificate has t irector, page 2 s Be P Medical Certification: 24 hours after death.
Funeral Director: A etely filled in by the fu within 24 hou

To the Fune

completely fi

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

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"natural",

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any lijury or other traumatic event, the Med once.

Physician /Medical

Examiner

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

						24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referr	red to medical				26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3□	DOA	Other: 4 Nursing H	ome 5 Residence 6	☐Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		ome, farm, street, fac fy)	ctory, of	ffice	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier (Check only one)	1 ☑ Certifying Pt 2 ☐ Medical Exa	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occur ation and/or investiga	red at t	the time, date and place my opinion, death occu	e, and due to the cause(s) irred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

10+1

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) CULWELL 32. Registre's Signature

2008 ▶

MT AIN MD

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year DONALD KOBER **FEBRUARY** 9:54 A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 15101 Interlachen Drive, # 407 Montgomery 8. Date of Birth (Month, Day, Ye Nov. 19, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) New York Age (In vrs. last birthday) 1√2 M 2□ F Months Days Hours Year 579-40-9761 74 1933 Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U. S. A. 15101 Interlachen Drive, # 407 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Salesman Jewe1rv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Kober Ann Fenster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10a. State

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-trans Physician/Medical attending p signed by the a Be Completed by page 2 certificate has 2 Medical Certification: within 24 hours after death.

Yo the Funeral Director: Af completely filled in by the fur

Division or Vital Records, P.O. Box 68760

Frances E. Kober	- Wife	1510	01 Inte	r1achen	Drive	, # 407,	Silver	Spring, Md.
20a. Method of Disposition 1 □ NBurial 2 □ Cremation 3 □		20b. Place of Dis cemetery, o			Dat	200.	Location - City or	Town, State
4 ☐Donation 5 ☐ Other (Specify	1)	Judean 1			2/10/2		lney, Ma:	
21. Signature of Funeral Service Licer	Stottlem	yer.	^{22. Name and} Danzans 1170 Ro	Address of Fac ky-Gold ckville	berg M Pike,	emorial (Rockvil	Chapels, le, Mary	Inc. land 20852
23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused thone cause on each line	death. Do not	enter the mode	of dying, such a	as cardiac or r	respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Ventricula:		asdia					Onset and Death Days
	Coronary A	consequence of):						20 Years
Sequentially list conditions,	b		sease					20 1ears
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						
	.d	zonsequence or).						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 l 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death :	3 □Ectopic pre 5 □ Other (spe				23d. Date of de Month	livery Day Year
Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cau	se given in Part	l.	23e. Did tobacci		o the cause of death? robably 4 Hunknown
25. Was case referred to medical				00 Diag		24a. Was an autopsy performed? 1 Yes 2	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 ☐ No
examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ent 3□ DOA			5K Residence	6 DOther (Co.	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time		: Injury at Work? 1 ☐ Yes 2 ☐	280	d. Describe how in	jury occurred	СПУЈ
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, Specify)	street, factory,	office	28f	Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,
29a. Certifier 1 Certifying Phyone 2 Medical Example 10 Medical Examp	vsician: To the best of r iner: On the basis of ex and manner stated	(amination and/or	ath occurred at investigation, in	the time, date a my opinion, de	and place, and eath occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
29b. Signature and title of confifier	il	MD		0518	17	29d. E	Date signed (Mont	th, Day, Year)
30. Name and address of person who o	ompleted cause of deat	h (Item 23a) (Type	e, Print)					

DHMH 17 Rev 1/2001

State Registrar Eric B.

31. Date filed (Month, Day, Year) FEB 13

Lieberman

1400 Forest Gues

Registrar's Signature

Rd # 200, Silver Spring, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Penny Kalkowski /Medical 2008 January 12:20a 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Fo. Months | Days | Hours | Min. | Dec. | 10, 1940 | Pennsylvania 5. Social Security Number 202–30–3720 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 T F 67 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Maryland 1 ¥Yes 2 No Montgomery Director Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11919 Stonewood Lane 20852 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Caucasian Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Institutes of Health permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trainmetts. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Winters Mary Carolyn Weatherby Winters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20814 19a. Informant's Name/Relationship (Type. Print) Sigrid Haines-Personal Rep. Bethesda Metro Center, Suite 460, Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-8-2008 Fort Lincoln Crematory Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Vicensee 23a. Part1. Enter the isease, or complications that can'ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Clastridium dificile Colitis
Due to (or as a consequence of): Examine The law requires that the death certificate be execu Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown <u> Herpes Simplex Virus Encephalitis</u> Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2X No Tension Pneumothorax 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient ပ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t

Box 68760

P.O.

Baltimore, Maryland 21215-0036

State Registrar

FEB 1 2 2008

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Eric J. Park, MD, 8600 Old Georgetown Road, Bethesda, MD 20814 Registrar's Signature

and manner stated.

PARK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D060117

29d. Date signed (Month, Day, Year)

1/29/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #5 Per FH C857atg-pf Maryland / Department of Health and Mental Hygiene state Registrar AMEND#18, 19aperFH 2/13/08, EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Catherine Elizabeth Kelly February 8, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

/Medical Examiner

Funeral Director

filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at "natural", or items 23a or edical Examiner must be r the Medical s 1 and 2 should be filed w of Health and Mental Hygier item 27 is marked other th other traumatic event, the

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

: If item 27 or other t

Pages '

permit. Page Department of Important: If any Injury or

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar as the l for use detached þ page 2 should funeral director, this within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

4:56 P Chevy Chase
If Under 1 Year If Under 24 Hrs. 8527 Gavin Manor Ct. Montgomery 5. Social Security Number 3 091-28-4173 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 M 2 XF 74 Dec 25,1933 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Montgomery Chevy Chase 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8527 Gavin Manor Ct. 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21√2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Business Owner Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond A. O'Connor Bertha Kilcen. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Vincent Mead/ 8527 Gavin Manor Ct., Chevy Chase, MD 20815 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem Feb 12,2008 Silver Spring,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OVABIAN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of cartific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40E BIDGLE 104 Abdallah

Registrar

State

31. Date filed (Month, Day, Year)

FEB

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2008

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December March Last La				1 - For State Registrar	State of N	iaryiand / Dep <i>Ce</i>	artment of H rtificate of L		, 0		
Power of Company Com					ast)				2. Date of Death	2000	3. Time of Death
Standier of December 1				Ana Luisa Ke	nnedy						8.05 n M
Part Part				4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or	Location of Death			
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Comparison Com	ary	shot and N s mai	_	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number, C	City or Town, State, 2	Zip Code)
Comparison Com		and 2		Ana L. Kennedy	/Daughter	98	04 Parkwoo	od Drive,	Bethesda	a, MD 208	14
Comparison Com	ore	of He of He fiten			Domaval from State		osition (Name of matory or other place	Feb.	Date 200	c. Location - City or	Town, State
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Physician Modical Examiner Physician Modical Examiner The ph	3ali	ermit Pepar nport ny In		21. Signature of Runeral Service Lice	nsee	2 F	2. Name and Address	s of Facility Collins	Funeral I	Home Inc.	
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Due to (or as a consequence of): Due to (or as a consequence of):			ē	Sequentially list conditions, if any, leading to immediate	b						
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	ĬŽ.	or Att ter de virect	ij		Zoe. Flace of III	ury - At home, farm, str tc. (Specify)	eet, factory, office				ıral Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PEBUARY 04 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAUI HUBBLY MD 9401 MEDICAL CENTER DRIVE ROCKULUE MARYLAND 20552 State 31. Date filed (Month, Day, Year)		pital ours at urs at Eral C		00-0-45							
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PEBUARY 04 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAUI HUBBLY MD 9401 MEDICAL CENTER DRIVE ROCKULUE MARYLAND 20552 State 31. Date filed (Month, Day, Year)		Hos 24 ho Fun etely i	dica	Check only 2 Medical Exa	miner: On the basis of	of examination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Mconon Mutoly, MD D0062562 FEBUARY 09 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAUI HUSBLY MD 9901 MEDICAL CENTER DRIVE ROCKUILLE MARYLAND 20352 State 31. Date filed (Month, Day, Year)		o the	Mec		and mainter St	atou.	29c. License	number	29d	Date signed (Monti	h. Dav. Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAD MAN HUBBLY MD 9901 MEDICAL CENTER DRIVE ROCKULUE MARYLAND 20552 State 31. Date filed (Month, Day, Year)		- S - O		9	lubbly M	D					
MADHAVI HUBBLY MD 9901 MEDICAL CENTER DRIVE ROCKUILLE MARYLAND 2052 State 31. Date filed (Month, Day, Year)	/ (0	-		- /						, 200
								RIVE RO	CKUILLE	MARYLA	ND 20552
Regulsicar FFB / / / / / / / / / / / / / / / / / /	2	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 2 200		ar's Signature	E)		,		

Amended #4c, nls, per phy., 02/11/08, Allegany Co. 1- For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Gary Eugene /Medical Facility Name (If not institution, give street and number) Examiner Memorial Hosipta 5. Social Security Number **Funeral** 1 X M 2 □ F 211-44-0147 Director Usual Residence of Decedent show 10a, State 10b. County "natural", or items 23a or 28a-f shovedical Examiner must be notifiled at Director PΑ Bedford death with the 10e. Street and Number 898 Mountain Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced as 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If them 27 is marked other than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be Ε. ပ 19a. Informant's Name/Relationship (Type. Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7. Age (In vrs. last birthday)

Artemas

Kifer

53

2 X No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. /

> 2. Date of Death Day q Kifer Februar 2008 4b. City, Town, or Location of Death Allegany 4c. County of Death 9. Bit inplace (State & Foreign

If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Months Days Hours

11/29/1954 West Virginia 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No

V.

10f. Zip Code 10g. Citizen of What Country? 17211 USA

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No Specify: Specify. White

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maintenance Packaging

18. Mother's Name (First, Middle, Maiden Surname)

Eulah

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

898 Mountain Road, Artemas. PA20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

Fairview Christian Cem. 2/13/2008 Inglesmith, PA

22. Name and Address of Facility Adams Family Funeral Home,

21. Signature of Funeral Service Licen 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

4 ☐ Donation 5 ☐ Other (Specify)

Constance R. Kifer / Wife

1 Burial 2 □ Cremation 3 □ Removal from State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Probable Myocardial Infarction Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify)

9☐Unknown

Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

23d. Date of delivery

14. Race - American Indian,

Collins

<24 hours

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 1□ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No pertormed? 2 No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 💢 No 27. Manner of Death 28a. Date of Injury (Month, Day Year)

5 ☐ Pending investigation

6 Could not be determined

2 X ER/Outpatient 3 DOA 28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 X Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0023371

29d. Date signed (Month, Day, Year) February 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 904 Seton Drive, Qamar U. Zaman, Cumberland, MD 31. Date filed (Month, Day, Year)

State Registrar

FEB 1 1 2008

Registrar's Signature

Division or Vital Records, P.O. Box 68760,

attending physician use for þ page 2 s this funeral

: If item 2

permit. Pages 1
Department of H
Important: If iter
any Injury or ott

Physician

/Medical

Examiner

burial-transit

the

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed After filled in by the

after death Director: To the Hospital within 24 hours a To the Funeral C

10 nKS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	tate of Maryland		tment of ificate of		Mental Hy	/giene Reg. No:)) () ()	05006
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 4. Facility Name (If not institution, give street)	eckliter		4b. City, Town,	or Location of Death	2. Date of D Month 02	Q5	Year OS- nty of Death	3: Time or Death
1 m	/ Funeral Director		Prince George's Hosp 5. Social Security Number 226-42-2891 6. Sex 1□ M	7. Age (In yrs. last	t birthday) Yrs.	Chever If Under 1 Year Months Days	r If Under 24 Hrs.	8. Date of Bi (Month, D	irth ay, (rear)	9. Birthol Coun Virg	lace (State or Foreign
	the Maryland 28a-f ehow notified at	rector	Usual Residence of Decedent 10a. State 10b. County MD Prince Geor		fown or Loca ar Mar				10g. Citizen o		0d. Inside City Limits 12 Yes 2 □ No
980	72 hours after death with the Maryland hatural', or tems 23a or 28a-1 show digal Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U.S. Amed Forces? Yes 2 M No 1 Yes, Give Year or Dates:		20722	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)	United	State ace - America ack, White, e	S an Indian,
Maryland 21215-0036	y within jiene.	Completed by	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12) 12	npleted)	(Give ki life. DC	nt's Usual Occu nd of work done ONOT use retire ral Wor	e during most of work ed) cker		16b. Kind of		lustry
laryland	2 should be and Mental Is marked of aumatic eve	To Be	Kent Stone 19a. Informant's Name/Relationship (Type, I				18. Mother's Nam Lelia Fr	idley ral Route Numb	per, City or Tow	n, State, Zip	Code)
Baltimore, N	es 1 an of Heal of tem 2 r other		Anastacio David Herr 20a. Method of Disposition 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	20b. Place ceme	e of Disposit etery, crema	ion (Name of tory or other pla	Street Co	Date	20c. Location Brentwo	- City or To	wn, State
■ Balti	permit. Page Department Important: Il eny Injury o		21. Signature of Funeral Service Licensee how the licensee of Funeral Service Licensee 23a. Part Library fallered to complication of the library fallered to complication of the library fallered to complicate the library fallered the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to complicate the library fallered to compli		34	Name and Address	ess of Facility Fo	rt Lind Road	oln Fur Brentwo	neral 1	Home
8760,	Departs the province of the pr	Ilcal Examiner	shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequent	ce of):	nia She	utie		y De	seon	Interval Between Onset and Death
O. Box 6	the death certifi y the attending p iched for use as	Physician/Medical	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal de: □Pregnant at time of death □ Unknown	ath 3□E	ctopic pregnanc other (specify) _	;y			ate of deliver	y Day Year
ords, P.	The law requires that the de ste has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions contribu	ting to death but not resultin	g in the unde	erlying cause gr	ven in Part I.	23e. Did t			e cause of death?
tal Rec	en: The law tificete has b tor, page 2 st	e Completed	25. Was case reterred to medical				26. Place of Deat	1 ☐ Yes	psy prmed! 20 No	Were autop prior to com death? 1 Yes 2	sy findings available pletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	atlon; To B	1) Natural 5 Pending Accident investigation	1 Inpatient 2 ER/	Outpatient b. Time of Injury	28c. Inju	her: 4 Nursing Ho	me 5□Resi)
Divis	spitel or Atte ours after de seral Directe filled in by t	l Certification;	4 Homicide	e. Place of Injury - At home, building, etc. (Specify)				City or To			
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	(Check only 2] Medical Examiner: (n: To the best of my knowled on the basis of examination and manner stated.	and/or inves	29c. Licens	opinion, death occuri	ed at the time,	cause(s) and m date and place 29d. Date sign	, and due to t	the cause(s)
R	- (2)		30. Name and address of person who compled the same at level	nis 3001 Ho	spital	Drive	503/8 Chever	ly Mi	207	108	
S AND S	Sta Registr		FEB 1 2 2008	32. Registrar's Signature	the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20 Sylvia Irene Tolley Lewis 汉 /Medical 4a: Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbu oastal 105P1C OMILO If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Pay, Yea 4/10/1925 5. Social Security Number 6\Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2XF 213-22-5015 82 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Dorchester Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2804 Hoopers Island Rd. 21622 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If item 27 is marked other the any Injury or other transmission. Crab Picker Shellfish 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Tolley Thelma Parker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Ocean Gateway, Cambridge, Frances T. Aaron/Sister MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) DorchesterMemorialPark 2.23.2008 21. Conature of Funeral Chice Licenses ²², Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIUE FAILURE HRART RECURRENT /Medical Due to (or as a consequence of): Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy perform 2/2110 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the name (s) and manner stated. 29a. Certifiei Medical (Check only

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

Maryland

Baltimore,

PWIS

State Registrar

29b. Signature and title of certifier

atura WAP (S

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

us

HOSPICA

Begistran Signature

P.U BOX

29c. License number

D0058410

1733 SANSBURY

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** FEB LUGA Irvin Hollis LaFollette /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth 10-1-1918 9. Birthplace (State or Foreign Country) West Virginia . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 ★M 2 ☐ F 89 Director 705–12–6586 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21750 209 Maryland Avenue U. S. A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced "natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) B&O Railroad 10th Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If Item 27 Is marked of any injury or other traumatic ever once. Robert L. LaFollette Lola M. Clark LaFollette မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangeline LaFollette 209 Maryland Ave., Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) tion 5 Cther (Specify) Funer Serve Se Spohrs Cross Roads 2-21-08 Berkeley Springs, WV 22. Name and Address of Facility Hunter-Anderson Funeral Home gnature 36 S. Green St., Berkeley Springs, WV 25411 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician (hronic /Medical Due to (or as a consequence of): **Examiner** CONONONY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral circtor, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 2∏ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

ARID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5HE

32. Registrar's Signature

why

29c. License number

0060396

29d. Date signed (Month, Day, Year)

Physician

/Medical

Examiner

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Betty 2008 10:10 Lee Littleton February 9, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 5/4/1926 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Salisbury 10f. Zip Code 10g. Citizen of What Country? 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No Specify: Specify: white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) clerk sales 18. Mother's Name (First, Middle, Maiden Surname) Mary Marvel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 Crestwood Circle, Salisbury, MD 21804 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomico Memorial 2/14/08 Salisbury, MD Park 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 TYes 2 🗆 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 9 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patroniez 1820 Sweet Ba 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MARION /Medical 14 2008 EBRYARY 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death If Under 24 Hrs. 8. Date of F HESTER HOSPITAL CENTE RIVER KENT If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Director 216-14-9248 DEC. 9, 1922 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ta Item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified 1 ☐Yes 2 No Director MD QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 OAK ST. 21617 USA 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 WWII WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) 12 SENIOR ENGINEER TECHNICIAN **ENGINEERING** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD DANIEL LEIBY GERTRUDE MARION WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau MARIAN LEIBY/WIFE 301 OAK ST. CENTREVILLE, MD 21617 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State CHURCH HILL CEMETERY 2/18/2008 CHURCH HILL, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEÉR RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the discase, or complete one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular lachacondi 10min /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Coronar ears and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown signed L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 disease 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending (Month, Day Year) 1. Natural 5 Pending Injury 124 hours after death.

• Funeral Director: A bletely filled in by the fu death. Investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

within 2

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29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

Cynwood & Br

29d. Date signed (Month, Day, Year)

Easton md

and manner stated.

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

WJZ

10 State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Stephen J. Sikorski, MD

FEB 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registar's Signature

DHMH 17 Rev 1/2001

912 Washington Road

29c. License number

03357

Westminster, MD

29d. Date signed (Month, Day, Year)

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 8, 2008 Physician 3:20 a M Dennis Guy Lipscomb /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□F 52 217-52-7764 Maryland Sep 10, 1955 Director Usual Residence of Decedent 10d. Inside City Limits t be notified at 10c. City, Town or Location 1 ☐ Yes 2 No Taneytown Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or USA 21787 3510 Harney Road an "natural", or Items 23s Medical Examiner must 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify ģ 3 ☐ Widowed 4 M Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of than Elementary/Secondary (0-12) College (1-4or 5+) Maryland Mechanic nit. Pages 1 and 2 should be filed with artment of Health and Mental Hygiene ortant: If item 27 Is marked other tha Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event, the Injury or other traumatic event or other event or other traumatic event or other event or ot 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Guy Lipscomb Violet Rose McCarter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 591 Chapel Road, Gettysburg, PA 17325 Lea Yox, friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 2/13/2008 Winfield, MD 4 □ Donation 5 □ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause of a city line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 | Unknown 1 ☐ Yes 2 ☐ No Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has nerforme certificate 2[25. Was case referre examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 🖊 1 Inpatient 2 ER/Outpatient 3□ DOA Other (Spe Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t tural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tipertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attendil within 24 hours after death.
• To the Funeral Director: A completely filled in by the fu WIL

> State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certific

30. Name and address of pers

Date filed (Month, Day,

FEB

2008

DHMH 17 Rev 1/2001

nd manner stated.

no completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State end #5 Per FH G878 4/14/08 JH Amend Item 5 per fh, 8878,04/28/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 Faith Lopez /Medical Feb. 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata If Under 1 Year Charles County Nursing Home Charles 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security (1)9244 **Funeral** Months 1 M 2 K F Days Hours Director 67 June 4, 1940 Maine Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show diçal Examiner must be notified at 1 X Yes 2 No Director Maryland Charles La Plata 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1025 Suffolk Drive 20646 hours after death Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 XX Yes 2□ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Charles County Board College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien important: If Item 27 is marked other the any Injury or other traumatic event, the once. of Education <u>Teacher</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Hunter, Sr. Hazel Trask Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lopez/ Husband 1025 Suffolk Drive, La Plata, Maryland, 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Cemetery Feb. 14, 2008 Augusta, Maine
22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee MUIZ6Z 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) var /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant gonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 1 Yes 2 certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** February 2008 1:00 A M Lillian Levitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizen's Nursing Home Frederick Frederick 8. Date of Birth (Month, Day, Year, June 24, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 97 Director 193-34-9040 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at YYes 2 No Director MD Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21702 USA 635 Wilson Place Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No δ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hyman Sher Bessie Goss ပ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trae Carol N. Levitt/daughter in law 635 Wilson Place Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 02/13/08 |Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22.Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) laser CardioVaseu to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1∐ Yes 26. Place of Death (Check only one) Be

Division or Vital Records, P.O. Box 68760, After this certificate has been si funeral director, page 2 should it • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica filled in by the

Baltimore, Maryland 21215-0036

To the l within 2 E.G. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**0**No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 12 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print)

and manner stated.

Robert L. Kaufmann, M.D. 300 West 9th Street Frederick, MD 21701

State Registrar

Certification: To

Medical

31. Date filed (Month, Day, Year) 13 FEB 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2008 Year **Physician** 6, 5:30 P M LEHR February ADA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 8. Date of Birth (Month, Day, Year) 08/23/1910 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X 1 97 Director 137-32-6591 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 1X Yes 2 □ No MD Bethesda Montgomery Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20814 U.S.A. 5124 Wickett Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items:
Important: If item 27 is marked other than "natural", or items:
Injury or other traumatic event, the Medical Examiner muones. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Stenbuck Harry Finkelstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bethesda, MD 20814 Naomi Fine - Daughter 5124 Wickett Terrace, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 02/10/2008 | Woodbridge, NJ 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, eral Service Licensee 21. Signatur 1170 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-trai Due to (or as a consequence of): Physician/Medical the attending phiched for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 3 140

9 Unknown Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 21 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 ☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check on one) and manner stated. within 2. 29b. Signat 29d, Date signed (Month, Day, Year)

5

State Registrar 31. Date filed (Month, Day, Year) FEB 1 3 2008 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician MINNIE LEVIN February 6, 2008 /Medica Examin

11:00 A M

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

miner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. Montgomery 4d. Montgomery											h						
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ral		5. Social Security Nu		6. Sex 1 ☐ M		. Age (In yrs.		//	If Under 1 Y Months D	ear ays	If Under Hours	24 Hrs. Min.	8. Date of E (Month, L	Day, Yea	r)	Co	hplace (State or Foreign untry)
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	Ö	17. Father's Name (First, Middle,	Last)			1	18. Mother's Name (First, Middle, Ma							en Surnam	10)	
	o Be	Joseph So	cherr					Fannie (Unknown)									
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		20a. Method of Disp							tion (Name o				Date	_			Town, State
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25. Was case referred to medical examiner?										Othe	ar.		th (Check onl)				
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	ion	1 Natural	5 Pendir	ng	(Month	, Day Year)	Inje		M 200.	Injury Work	rat ? Yes 2□	I No.	260. Describ	e now in	jury occur	ieu	
	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	Re Place o	of injury - At ho	ome farm	n stree			163 2]140	28f Location	/Street	and Numb	ner or Ri	ural Route Number,
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	S S	29a, Certifier	1 Certifvii	ng Physicla	n: To the b	pest of my kno	wledge.	death (occurred at t	he tim	ne, date a	ind place.	and due to ti	ne cause	(s) and ma	anner as	s stated.
`	Medical Certification: To			Examiner:		sis of examina											e to the cause(s)
-	Me	29b. Signature and	title of certifie						29c. License number 29d. Date signed (Month, Day, Year)				th, Day, Year)				
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		30. Name and addre	es of person	1 110	eted cause	of death (Iten	n 23a) (T	ype. Pi	rint)		1810)1 P1	rince H				¥) 51 0 0 0
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		1	. Decedent's Name (First, Middle	. Last)						2. Date of Dea		Year	3. Time of	
	Physicia		Roland		Le	ee				Februar	-		4:30	AM
	/Medic		a. Facility Name (If not institution	give street and nur	mber)				Location of Death	1		ounty of Death		
			Heartland Healt	h Care Ce	nter		Hyati			1		ince Ge	orges	r Foreign
	Funeral Director		5. Social Security Number 579–46–4539	6. Sex 1 🔯 M 2 🗆 F	7. Age (In yrs. la 73	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/13/1	934		ington	
	D .	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside Cit	ty Limits
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	28a-	Director	10e. Street and Number				10f. Zip 0					en of What Co	untry?	
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	Jeath Tis 2:	era	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.S	S. 13.	Was Decede	nt of H	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	1	 Race - Amer Black, White 	ncan Indian, e, etc.	
36	72 hours after death with the Maryland Insturat, or items 23s or 28s-f show disal Examiner must be rediffed at	by Funeral	1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced		2 □ No ive		1 ☐ Yes 2		Specify:			Specify: B1	.ack	
O ₁	2 hou	ed	15. Deceden	's Education		16a. Dece	dent's Usual	Occup	ation	rkina	16b. Kir	d of Business/	Industry	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatin and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Myclical Examinar must be indifficated any injury or other treumatic event, the Myclical Examinar must be indifficated and once.	To Be (17. Father's Name (First, Middle, Walter Lee	Last)					Pear1	Clackley				
Mary	d 2 shouth and N		19a. Informant's Name/Relations Pearl Lee /	hip <i>(Type, Print)</i> Mother						ural Route Numbe , Washin	gton	, DC 20	011	
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Baltimore,	permit. Pa Departmen Important: any injury ance.		4 □Donation 5 □ Other (S 21. Signature of Funeral Service		V	2	2. Name and	d Addre	ss of Facility Jo	hnson &			neral H 20011	lome
B	88 2 8 8		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused the deat	h. Do not er	16 Ker	ned of dyir	y St. Nw ng, such as cardia	, Washir c or respiratory a	rrest,	1, DC	Approxima Interval Be Onset and	tween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. C Due to	ardiopul o (or as a conseq [yocardia	Lmonar uence of): al Inf	y Arre	est						
60,	certificate be executed and nding physician and use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S C	c (or as a consequence of consequenc	f the	Lungs							
687	rtificate by physical as the b	dica		d										
.O. Box 6	death e atter	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregna birth 2 Feta gnant at time of c	death 3	□Ectopic pr □ Other (sp		у			23d. Date of de Month	Day	Year
Δ.	ires that the d signed by the d be detached	d by Ph	Part II. Dther significant condit	ions contributing to	death but not res	sulting in the	underlying c	ause gr	ven in Part I.		tobacco (use contribute t	o the cause of Probably 4	
Division of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	ompiete								24a. Was auto perfi 1 \(\text{Yes}		death?	utopsy findings completion of s 2 2 No	s available cause of
tal		BeC	25. Was case referred to medic	al						eath (Check only	one)			
>	ysici	To E	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1	Inpatient 2	ER/Outpati		JA		Home 5 ☐ Res			ecify)	
0	ding Ph. After thi funeral	:uc	27. Manner of Death 1 X Natural 5 ☐ Pend	/8.4/	te of Injury onth, Day Year)	28b. Time Injury		8c. Inju	ry at ork?	28d. Describe	how inju	ry occurred		
visior	Attending Physicien: or death. ector: After this certifics by the funeral director.	Certification:	2 Accident inves	tigation I not be 28e. Pla	ace of Injury - At h	nome, farm,	M street, factor		Yes 2 No	281. Location City or To	(Street a	nd Number or F	Rural Route Nu	ımber,
D	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.			ing Physician: To t	the beat of our less	awladga da	ath occurred	at the	ime, date and pla opinion, death oc	ce, and due to the	cause(s) and manner a d place, and du	as stated. ue to the cause	e(s)
	To the H within 24 To the Fl complete	Medicai	one) 29b. Signature and title of certif	and ma	anner stated.			c. Licer	se number		29d. Da	te signed (Mor	nth, Day, Year))
	6)	30. Name and address of person	n who completed ca	ause of death (Ite	m 23a) (Typ	e, Print)	D-10					2000	
K	- 6		Dr. Victor Ony			5 Hano	ver Pa	arkv	ay, Gree	enbelt, N	4D :	20901		
'		ate rar	31. Date filed (Month, Day, Yea	r) a 32	. Registrar's Sign	ature	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of F rtificate of I			, ,	ene g. No.		
	411		Decedent's Name (First, Middle, La.	st)		<u></u>			Date of Deatl Month	200	Year	3. Jime of Death
	Physici /Medic		FRANCES H.	LANAM					BRUARY	7, 20	08	12:20 P.M
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o		of Death		4c. County o		
			REEDER'S MEMORI.		(In up lost hirthday)	BOONSI If Under 1 Year		r 24 Hrs. 8.	Date of Birth	WASH		
8.	Funeral Director		220-26-7669	ex 7. Age	(In yrs. last birthday) 76 Yrs.	Months Days	Hours	Min.	(Month, Day, AN • 11	,1932		ace (State or Foreign try) BAMA
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					1	0d. Inside City Limits
	Maryl f sho	tor	MD WASHI	NGTON	HAGERST	OWN						1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wh	nat Coun	try?
	th wit	al D	1120-02 KENLEY	AVENUE		21740				U.S.A		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	lispanic O an, Mexica Specify		Yes or No- an, etc.)	14. Race Black Specify:	, White,	
5-0	72 ho natur dicai	eted	15. Decedent's Education (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during mo	st of working		16b. Kind of Bus	iness/Ind	dustry
12	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired LF—EMPLO	,			DAY C	ARE	
	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		<u> </u>		her's Name <i>(Fi</i>	irst, Middle, N	Maiden Surname		
lan	ld be ental ked o	To Be	SAMUEL MADISON	HUBBARD			BE	ETTY E.	RAY			
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Num	ber or Rural R	oute Number,	City or Town, S	itate, Zip	Code)
	and 2 salth s		SHIRLEY KEHNE /	DAUGHTER		SACHS RO	OAD,					
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 By Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special			osition (Name of matory or other place) BY CEMET!		02/11/	1	FORT	-	
Balt	permit. Departr importr any inj		21. Signature of Funeral Service Lice	uschure	/	2. Name and Addre UPCHURCH 202 GREI	ALTE F	JERAT, H	OME, P	.A. RLAND,	MD_2	1502
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. myoca	a consequence of):	arction					_	1-2 M.
	Examiner	<u>.</u>	Sequentially list conditions,	b. (Kuperte	Maliva a consequence of):							46.Ars
	ted nsit	Examiner	Cause (Disease or injury	Donago	/	vanced					-1	(18A15
,	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence of):	0000						1
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	rtifical ng ph	Medi	IF FEMALE:		-10							
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	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions	contributing to death bu	at not resulting in the u	nderlying cause giv	ven in Par	t I.	23e. Did tob		bute to tl 3	ne cause of death? pably 4 🗗 Unknown
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ta	ian: rtifica ttor, p	Be C	25. Was case referred to medical				26. Pla	ce of Death (C		(
r <	Physician: r this certificaral director,	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	II 3 DOA	_			ence 6 □Othe		y)
Division or Vital	ine ifte	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju		Wo			d. Describe ho	ow injury occurre	ed	
Sio	or Attending after death. Director: After in by the fune	cati	2 Accident investigatio 3 Suicide 6 Could not b	e 28e Place of init	rry - At home, farm, st]Yes 2[Location (St	reet and Numbe	r or Rura	al Route Number,
<u> </u>	or A	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	,,,			City or Town	n, State)		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier 1 ☐ Certifying P (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the tinvestigation, in my	ime, date opinion, d	and place, and leath occurred	d due to the c at the time, d	ause(s) and mar late and place, a	nner as s and due t	tated. o the cause(s)
	o the //thin (Mec	29b. Signature and title of certifier	and mainter ste		29c. Licens	se numbe	r	2	9d. Date signed	(Month,	Day, Year)
M			> 4	Qudi	m D	D46	5561			Feb.	7, 2	800
	5		30. Name and address of person who		eath (Item 23a) (Type,	Print)						
	MAS		Dr. Ghazala Qad	ir, 20311	Lappans Ro	ad, Boons	sboro	MD	21713			
	Sta Regist		31. Date filed (Month, Day, Year)	2008 32. Registra	ar's Signature	Gode						

			Please 1	ype or Print in Bl State of Maryland				•	_	
			1 - State Registrar		•	tificate of E			g. No. 2008	0599
П	Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month February		3. Time of Death 01:49 A M
	/Medi Examir	cal	4a. Facility Name (If not institution, give			4b. City, Town, or		геолион	4c. County of Death	
	Exami	ler	Harford Memorial			Havre de	Grace		Harford	
	Funeral Director		5. Social Security Number 6. Sex X	7. Age (In yrs. las	1.1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day.) March 31	9. Birth	place (State or Foreign intry) Viyland
	iryland show		Usual Residence of Decedent 10a. State 10b. County		Town or Lo					10d. Inside City Limits
	he Ma 88-f	Director	Maryland Harford	Havi	ie de	Grace		140	- 07:	1 XYes 2 No
	with (Dir	10e. Street and Number 102 Bayland Dr. Un	:+ 20		10f. Zip Code 21078			g. Citizen of What Cou	intry?
	me 23	era		12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Spe		14. Race - Amer	
980	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "naturet', or terme 23a or 28a-f show event. I'm Madical Exarring must be notified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Xes 2 No 1943 If Yes, Give Year or Dates: 1945	-	Yes, specify Cubar	specify:	Rican, etc.)	Specify: (1) Mile	
Maryland 21215-0036	hin 72 ho B. An "natur Medical	pieted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	ent's Usual Occupat kind of work done du OO NOT use retired)	uring most of workil	ng	6b. Kind of Business/I	
21	filed wit Hygiene ther the	Соп	12		Superi				ivil Servi	ce
and	B E B	Be	17. Father's Name (First, Middle, Last) Paul Kauliman MCC	au l'au			18. Mother's Name	Mae Hill		
Z	s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 ie marked other than other traumatic event.	2	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street a			City or Town, State, Zi	ip Code)
	and 2 palth a n 27 is		Ermalee Hall McCau	ley (wife)	02 B	yland Dr.	. Unit 20	Havre d	le Grace, I	tD 21078
Baltimore,	m O		20a. Method of Disposition 1	emoval from State cem	etery, crem	sition (Name of natory or other place on Garde))		berdeen. M	
Salti	permit. Page Department of important: if eny injury or once.		21. Signature of Funeral Service License		22	Name and Address	of Facility Zell	man Fune	ral Home.	P.A.
	0 0 = 0	Н	23a Part I Enter the disease or compli	SUMMAN Caused the death					de Grace,	Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	CON	Jaes.	TIVE HEA	KT FALL	ure		Interval Between Onset and Death
68760, <	Examiner and transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer Due to (or as a consequer Due to (or as a consequer	150 nce of):	НЕМІС	CARDI	O MYOPA	744	12 YEARS.
P.O. Box 68	law requires thet the death certificate be exe es been signed by the attending physician a. . 2 should be detached for use as the burial-i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year
	res thet igned b be deta	ρ	Part II. Other significant conditions con	1 // //	ng in the un	derlying cause giver	n in Part I.		cco use contribute to	
Records,	w require been si should t	eted	14YPERTER	BOW, TOWN	16 /	NJUFFI	ciency	1 Yes		bably 4 Unknown
al Rec	The ate h page	Completed							prior to death?	opsy findings available ompletion of cause of 25 No
Vital	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER	/Outpatient	Other	26. Place of Death		ce 6 Other (Spec	.6.A
Division of	Attending Phy r death.		27. Manger of Death 1 Natural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injury		28d. Describe how		,,,,
Divisi	or Atter efter dea Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: Within 24 house ster death. To the Funerei Director: Afferthis certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opi	a, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	m		29c. License	number 0927	290	Date signed (Month)	Day, Year)
11	140		30. Name and address of person who go	mpleted cause of death (Item 23	la) (Type, F	Print)	on hib !	Harron a	la Conna	4D
4	Sta	te	31. Date filed (Month, Day, Year)	32. Regionar's Signature	1 10	eur um	Uh /100/	1/1 VKE a	e crevel	The state of the s

DHMH 17 Rev 1/2001

Registrar

FEB 2 7 2008

			1 - For State Registrar	Otate of Ma	ii y iai i		tificate of		i wentai ny	/gien Reg. N		08	05000
	Physici		Decedent's Name (First, Middle, La KENNETH	ost) OLIVER	ΜZ	ARTIN]	79		2. Date of D. Month FEBRU.		^{ay} 16	პშ′ი 8	3. Time of Death 5:30 PM
	/Media Examir		4a. Facility Name (If not institution, give	re street and number)	1.17-	XXXX	4b. City, Town, o			-	c. County	of Death	
Funeral											RLES		
Funeral Director			299-48-8611 1/2 59 Yrs. Months Days Hours Min. JUL. 29, 1948 NEW MEXICO									MEXICO	
yland	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10	d. Inside City Limits
he Mar			MD CHARLES	5	WAL	DORF							1 ☐ Yes 2X No
h with t		al Dir	10e. Street and Number 13400 GREEN P	INE ROAD			10f. Zip Code 2060	1		-		/hat Count • A•	ry?
er deat		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-		e - America k, White, e	
hours aft		b	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1√Xes 2 N If Yes, Give Year or Dates:	64- '	69	∰Yes 2□ No	Specify:	SOUTHW	EST	Specify	WHI	TE
13-6		Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	ent's Usual Occup kind of work done OO NOT use retire	ation		16b. I	Kind of Bu	siness/Indi	ustry
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d be file		Be	17. Father's Name (First, Middle, Last						ame (First, Middle			e)	
2 shoul		10	OLIVER MARTII 19a. Informant's Name/Relationship (19b. Mailin	g Address (Street		ORED PI			State, Zip (Code)
≥ 0			CHRISTINES MARS	rines/wif					RD. WAL	_		D 20 City or Tow	
Pages			1 Donation 5 ☐ Other (Specific			VETER	sition (Name of natory or other place RANS CE	м. ¦267	BRUARY 2008	CH	ELTE	NHAM	, MD
permit.			21. Signature of Funeral Service Lice	E Silv		5.6	Name and Addre	ess of Facility	AYMOND AVE.,	FUNI	L. S	ERVI	CE, P.A.
	5.3		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	th <i>e</i> death. e.								Approximate Interval Between
	rs after death. ral Director: After this certificate has been signed by the attending physicis lied in by the funeral director, page 2 should be detached for use as the but		Immediate Cause (Final disease or condition resulting in death)	a. LU	N G		ANC	ER					Onset and Death
Ex		_	Sequentially list conditions,	b									
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the death cer		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal o	death 3	Ectopic pregnancy Other (specify)	/			23d. Date Mor	of deliver	y Day Year
es that			Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contri	bute to the	cause of death?
v requir										Yes 2	_	3 ☐ Proba	
The lay		Completed							24a. Was auto perfo		d p	/ere autop: rior to com eath? ∐Yes 2	sy findings avail <i>a</i> ble pletion of cause of □ No
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Attend		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ry - At horr	ne, farm, stre		Yes 2 □ No	28f. Location (Street a	nd Numbe	r or Rural	Route Number,
pltal or			Tity or Town, State)										
he Hos		Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Tot		Σ	29b. Signature and title of certifier	ugardl	01	i b	29c. Licens	e number	64	29d. Da	ate signed	(Month, D	ay, Year)
α	XI		30. Name and address of person who				Print) 10	583-	THEOL	ORT	= C	REE	N BLVD
		to	VIDYA SAGAR 31. Date filed (Month Pay Meach.	ANMA	N G	ANDL	A h	HITE	PLAI	LN	M	D -	20695
	Sta Registra	_	31. Date filed (Month Day Year)	32 Registra	1	Age	We will						